WEST FLORIDA HOSPITAL
EDUCATION AND PROFESSIONAL DEVELOPMENT SERVICES

O. M. E. N.

Orientation Mandatory

Education Notebook

WEST FLORIDA HOSPITAL
ORIENTATION MANDATORY EDUCATION NOTEBOOK
(O.M.E.N.)

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West Florida Hospital
Mission, Values and Guiding Principles

SCOPE: This policy applies to the Medical Staff, Administration and employees of West Florida Healthcare and all ancillary and satellite components.

PURPOSE: To establish standards of performance excellence by defining the mission, values and guiding principles of West Florida Healthcare.

POLICY: Quality at West Florida Hospital means providing services that meet or exceed the needs or expectations of patients and their families, the physicians, payers, our fellow employees and the communities that we serve. Achieving quality is a process of regular measurement, systematic feedback, continuous improvement and innovation. Everyone in the Hospital has a responsibility to do their job in as high a quality manner as possible and to continuously seek to improve the way we provide services to our customers.

MISSION AND VALUES STATEMENT. Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.

In pursuit of our mission, we believe the following value statements are essential and timeless.
- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

PHILOSOPHY. We believe the following principles to be true and timeless.
- Our number one focus will always be on patient care.
- We are committed to caring for people with compassion and kindness.
- We are committed to consistently providing high quality care and service to our patients.
- We will work closely with and enthusiastically support the communities that we serve.
- Our success is dependent upon attracting, developing and retaining our greatest asset -- our people.
- We will foster an environment that:
  - Treats all people with dignity and respect
  - Encourages open and honest communication
  - Emphasizes and rewards teamwork
  - Builds loyalty and trust
- We believe in holding people accountable to our values and principles through fair and accurate metrics.
- We believe our business is best managed and run at the local level, giving responsibility and authority to those closest to the delivery of patient care.
- We will continue to evolve and grow our business in order to successfully fulfill our mission while unswervingly adhering to our values and principles.
- We will constantly look for ways to innovate and improve the quality of our care and service.
- We will maintain a strong, viable financial position that will continue to reserve the respect and give confidence to our shareholders.

West Florida Hospital
Staff Rights Mechanisms

SCOPE: This policy applies to all employees of West Florida Healthcare.

PURPOSE: To affirm West Florida Healthcare's policy that the cultural values or religious beliefs of patient care givers will be considered an aspect of patient care assignment and may be taken into account when there is a communicated and direct conflict between the employees values or beliefs and the patients care/treatment. This is an employee right.

POLICY: The facility is aware of and will abide by federal and state laws prohibiting discrimination based on religion. However, West Florida Healthcare does not make a general practice of extending religious protections to situations that extend beyond the scope of those laws. Also, West Florida Healthcare expects staff to participate in patient care procedures if a substitute or alternative does not exist to accommodate the employee's request.

PROCEDURE: The mechanisms that address the evaluative process by which requests are reviewed include:

1.   As a part of the orientation process, the job duties are discussed and describe the type of patients served and care given. The types of care described include a variety of real situations that occur frequently in hospital settings. Employees are then asked to identify and discuss any potential conflicts they foresee. The results of this particular discussion will be maintained in the personnel file and/or with the compensation file. Reasonable efforts are made to provide alternative scheduling and/or placement should such a conflict exists.

2.   If, during the course of an employee's tenure with West Florida Healthcare, a conflict of this type develops while the employee is on duty, the supervisor will ensure that the employee is immediately removed from contact with the affected patient so that patient care will not be compromised. As soon as possible, the supervisor will notify appropriate management, including the Vice President, Human Resources, of the incident.

3.   When an employee has exercised his/her right under this policy, the care or treatment of the patient shall not be compromised. The Supervisor who receives the notice from the employee will make coverage arrangements for staff that are qualified to care for the patient. The physician who is attending or ordering the care or treatment may personally deliver it. In the event that all qualified staff members refuse to participate in the care or treatment and a physician is not able to provide it, reasonable efforts will be made to secure the desired care at another facility. Patient care will not be compromised while these efforts are being made.

At this point, the Vice President, Human Resources will activate the Employment Dispute Resolution Process-(Policy IV-59). During this process, the employee is invited to explain the incident. Once that information is gathered, it will be evaluated in the context of the incident itself and the implications of future such incidents. Every effort will be made to assure that reasonable accommodations are discussed and considered.

Dimensions of
TEAMWORK

A group does not a TEAM make! A group is defined as people assembled together that have some relationship, for example the PTA meeting members. They may have their own agenda to pursue. The same is true for a theater audience or a ball game crowd.
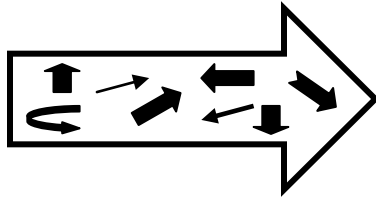
The group is much like the above arrow. Everyone is at the location for the same purpose, but they all differ in their direction.

A **TEAM** is a group of people working together to achieve a common goal.
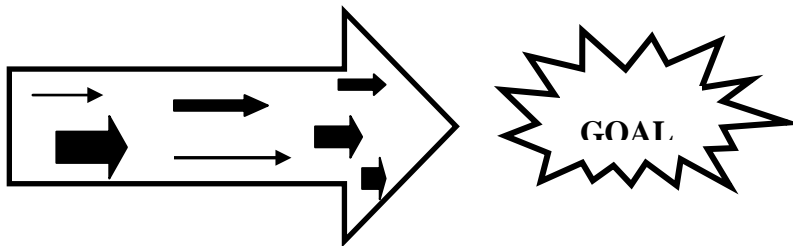
The Team is much like the above arrow. Even though each arrow is different there is a common direction "a goal" of all the participants.

Teams are essential in providing cost-effective high quality healthcare. Teams must have clear goals, use creative problem solving, and demonstrate mutual respect and support. Each individual member of the team is essential in the successful completion of the goal.

TEN ESSENTIAL ELEMENTS OF TEAMWORK
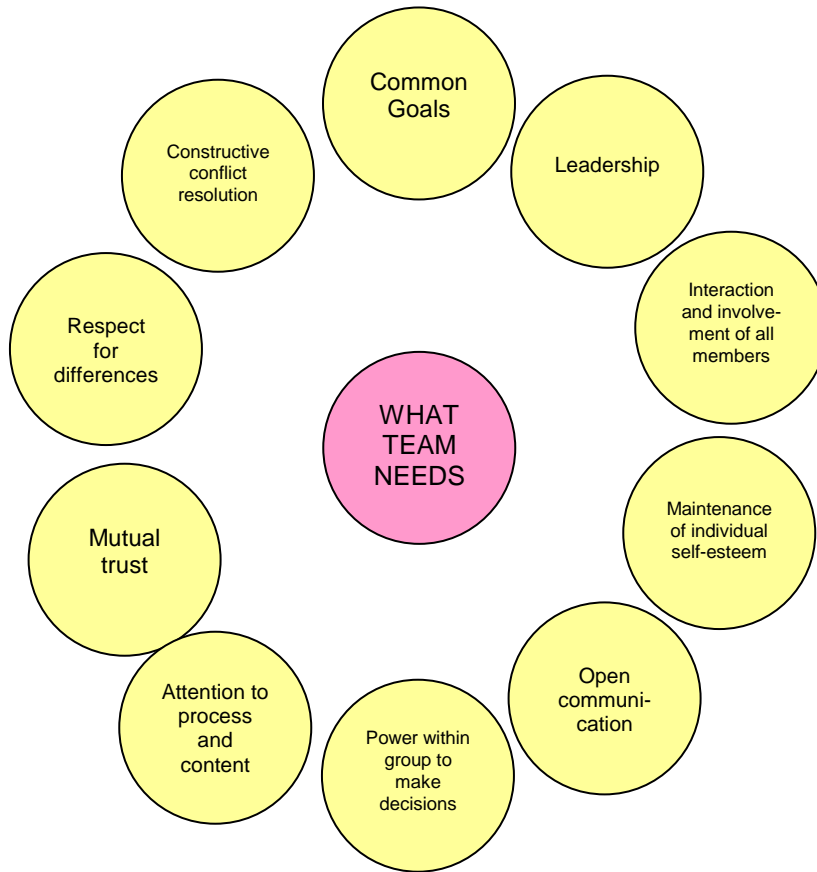
1. *Common Goals.* West Florida Hospital is committed to deliver high quality healthcare in the community we serve with honesty, fairness and respect for each individual.

2. *Leadership*. Leaders help coordinate the work of the team, have good communication skills, and know how to get everyone involved.

3. *Interaction and involvement of all members*. To achieve a common goal, all team members must contribute actively. Holding back creates problems for the team.

4. *M*aintenance of individual self-esteem. Each member's contribution to the team must be heard, valued, and acknowledged.

5. *Open Communication*. Team members need to feel they can speak their minds and should have ample time to communicate; share information; discuss issues.

6. *Power within the team to make decisions*. The work of the team should center on the things it has the power to influence.

7. *Attention to both process and content*. For people to work well together as a team, attention must be paid both to the process used to do the work and the content of the work or task. Process includes attention to how people get along together, how the work is structured and distributed, and what the general rules of working together are.

8. *Mutual trust*. Trust depends on how the leader and members treat one another. Members and team leaders need to discuss how their behaviors and attitudes affect trust.

9. *Respect for differences*. Team members need to feel they can disagree and be different while knowing and respecting the needs of others.

10. *Constructive conflict resolution*. Conflict is natural. When it surfaces, it must be addressed in a healthy way. Unresolved conflict leads to less-than-adequate performance, resentment, and lack of motivation.

*** Remember ***
Together **E**veryone **A**chieves **M**ore

Diversity in the Organization

Diversity is those things that make us different—those things that make us unique. In our health facility the staff members and our patients have a variety of multi-culturally diverse backgrounds. We must understand and appreciate the richness of all cultures.

Differences can help us achieve great things. And yet those differences can also prevent us from achieving. When meeting a person for the first time, we know almost nothing about them, apart from the way they look or speak. As we get to know the person, we add to our knowledge of who they are. Yet often, even before shaking a person's hand, we've already made judgments. Skin color, gender, hairstyle, clothing, age—all of these things remind us of someone we have known or been told about. There's nothing surprising about that. It's just a natural part of how human beings process information.

Unfortunately, differences have a way of putting up walls between people. You meet a person, and you see only those things you already know—or think you know. And you lose the chance to get to know someone new.

When you find a way to step beyond a person's differences, you open a door. Once beyond that door, you can begin to see the things that link the two of you together.

You're likely to find that you have more in common with that person than you ever could have imagined. That's how strong relationships begin. And strong relationships lead to trust, which creates more innovation and understanding between people.
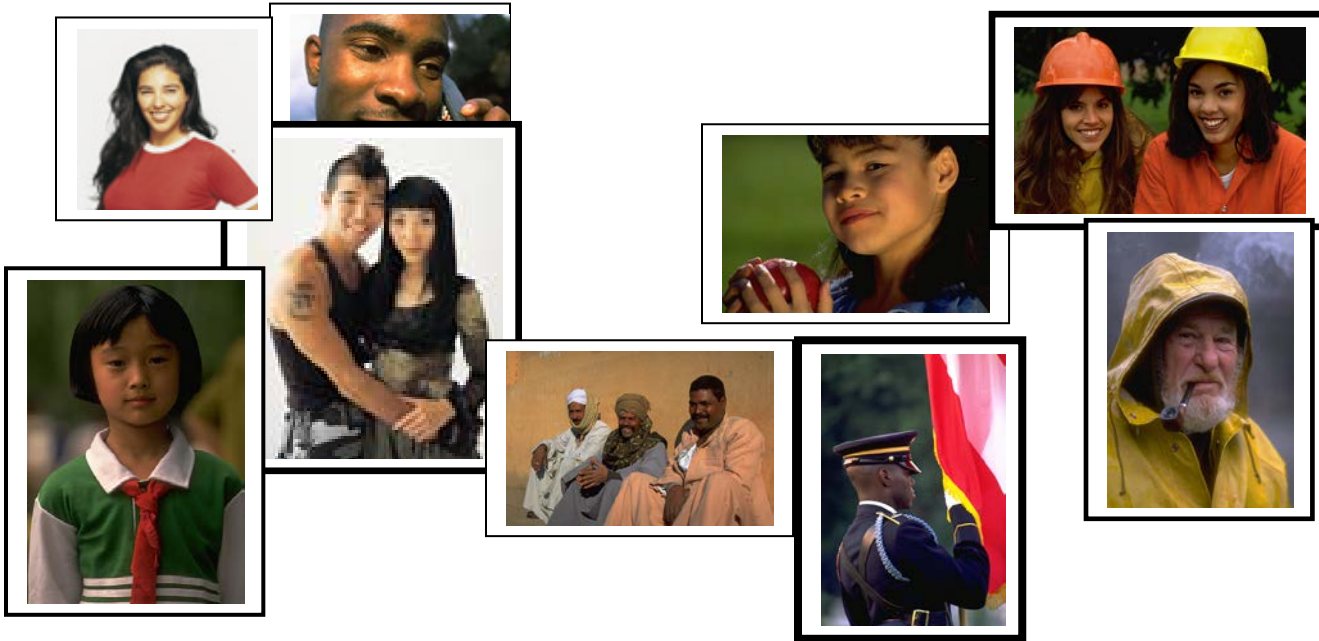
Putting Patients First

Putting Patients First is West Florida Hospital's philosophy of educating and empowering patients to become more actively involved in their healthcare. This involves the patient taking responsibility and knowing their rights with their healthcare plans, providers, and employers so that they receive the most appropriate, high quality and cost effective healthcare possible. We believe when this is implemented not only patients, but the entire healthcare system, will benefit.

If a patient receives helpful, supportive, and motivating information they will play a more effective, positive role in their own care. This philosophy is incorporated at the WFH orientation process by:

- Including the philosophy statement in the new hire orientation program
- Addressing various issues within the Patient Handbook
    - Patient Safety   ♦ Patient Responsibilities
    - Patient's Rights
- Incorporating the "Putting Patients First" philosophy in all job roles.
- Identifying issues that address the needs of the patient
    - Medication safety
    - Analysis of technology and data to identify and prevent errors
    - Increasing awareness and cultural diversity for the staff

1. What happens if a patient is hearing or visually impaired or cannot speak English and he/she needs medical treatment at the hospital?

- Contact your Department Supervisor or the House Supervisor. The policy can be found in the Meditech Library Administration Policy Manual – I-54.
- TDD telephones are available from Plant Ops and are in the emergency department.
- Telephones with volume control for the hearing impaired are available through Plant Ops.
- Plant Operations can provide closed caption television for inpatient televisions.
- Communication boards can be provided for a patient with an identified need.
- The House Supervisor has access to a list of employees who can assist with language interpretation. They can also provide access to the language line, a contracted service. An interpreter for the hearing impaired is available upon request.

It is the law that accommodations must be made free of charge for a patient when requested.
How are patient complaints handled?

- The patient is informed of their right to present complaints and how to do so, upon admission to the hospital
- The patient or family can voice a complaint to any person within the hospital
- The staff member will then notify the Shift Supervisor/Charge Nurse or House Supervisor, who will address the situation with the appropriate Department Head
- If they cannot resolve the issue, they will refer the issue to the Chief Nursing Officer or Director of Risk Management.

WFH PATIENT BILL OF RIGHTS

West Florida Healthcare is a committed advocate for its patients, their families, and their healthcare representatives. While we recognize that each patient is an individual with unique healthcare needs, we believe that all patients have basic rights in the receipt of their health care.

West Florida Healthcare affirms the following patient rights.

1.   The right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, age, gender, physical handicap, or ability to pay.

2.   The right to the hospital's reasonable response to his/her request and needs for treatment or services, including emergency conditions, within the hospital's capacity, its stated mission, and applicable law and regulations.

3.   The right to receive a written statement of his or her rights, to be well informed, ask questions, and be involved in the decision making process related to the development and implementation of his or her plan of care.

4.   The right to make informed decisions with your doctor and to understand the benefits and risks of each treatment, what you can reasonably expect from the treatment and any long-term effects it might have on your quality of life, as well as what you can expect when you leave the hospital. You may accept or refuse treatment based on these decisions.

5.   The right to appropriate assessment and management of pain, and to be involved in care planning and pain management.

6.   The right to be informed about services not available or not covered. You also have the right to know the identity of doctors, nurses and others involved in your care and to know when they are students, residents or other trainees.

7.   The right to the confidentiality of his/her clinical record and financial information and to access information contained in his/her clinical records within a reasonable time frame.

8.   The right to personal privacy and security and an environment that contributes to the patient's care and sense of well being, free of all forms of harassment and abuse or neglect.

9.   The right to pre-designate a representative to make healthcare decisions on his/her behalf in the event he/she becomes incapable of making them and to formulate advance directives, including the withholding and withdrawing of life-sustaining treatment and to have hospital staff and practitioners who provide care comply with those directives.

10.   The right to have a family member or representative of his/her choice and his or her own physician be notified promptly of his/her admission to the hospital and the right to exclude any and all family members from participating in his or her healthcare decisions.

11.   The right to religious, pastoral, or spiritual services and to care sensitive to a patient's end-of-

life needs.

12.   The right to be given individualized care that is considerate and respectful of the patient's personal values and beliefs, appropriate to his/her age and developmental needs and sensitive to different treatment practices.

13.   The right to request and participate in ethical issues and questions that arise in the course of his/her care and treatment, including issues of conflict resolutions, withholding resuscitative services, foregoing or withdrawal of life-sustaining treatment, and participation in investigational studies or clinical trials.

14.   The right to be advised, through the informed consent process, if the hospital proposes to engage and/or perform experimentation or other research/educational projects affecting his/her care or treatment and right to refuse to participate. The patient has the right to be advised of a full description of expected benefits, risks and potential discomforts, alternative services and a full explanation of procedures to be followed. They have the right to refuse to participate and must be informed that refusal will not compromise their access to care.

15.   The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation.

16.   The right to access protective services including guardianship, conservator ship, and advocacy services, and be informed of available patient support services, including self-help groups.

17.   The right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care and the financial consequences of using uncovered services or out-of-network providers.

18.   The right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and the right to receive a copy of a reasonably clear and understandable, itemized bill, and, upon request, to have charges explained.

19.   The right to means of communication, as appropriate to the condition of the patient, including speech impaired, and in a language they can understand at no cost to the patient.

20.   The right to express his/her concerns, questions, suggestions, or grievance regarding care and services and participate in the grievance process as outlined in the Patient Handbook under Patient/Family Concerns.

21.   The right to be informed about anticipated outcomes of care, as well as unanticipated outcomes and the right to be told if anything unexpected and significant happens during your hospital stay.

West Florida Healthcare affirms the following patient responsibilities:

1.   The responsibility for providing to the best of his/her knowledge accurate and complete information about present complaints, past illnesses, hospitalizations, medications, dietary

supplements, allergies, advanced directives, spiritual wishes and other matters which may be relevant to his/her health or care including any network or admission requirements under your health plan.

2.   The responsibility for understanding and acknowledging his/her plan of care and what is expected of him/her and to tell your caregivers if you need more information about those treatment choices.

3.   The responsibility for informing your caregivers if you have concerns about your care or have pain. The patient also has the responsibility to follow medication, diet and therapy plans to the best of his/her ability.

If you have questions, grievances, suggestions, ethical issues or concerns, please direct them to the department director or unit nurse manager.

PAIN MANAGEMENT

Pain management is an important aspect of the recovery process for any patient admitted to West Florida Hospital. Our organization is dedicated to keeping patients as comfortable and pain free as possible during their stay, and considers every employee to be a patient's advocate regarding pain management and pain control.

Employees can help contribute to meeting goals of pain management by:
- Informing patients of their rights to:
  o Receive information and education about pain and pain relief measures.
  o Receive answers to their questions regarding pain and pain relief measures.
  o Discuss their medical plan and personal goals for pain management.
  o Be treated with respect and concern at all times, and be believed when reporting pain.
  o Have their cultural beliefs included in their pain management plan.
  o Receive prompt response from the staff when reporting pain.
  o Receive adequate pain management with best possible pain relief treatments.

- Bringing any reports of pain from the patient to the nursing staff's attention.
- Assessing the patient's pain level prior to conducting activities such as transferring or moving the patient.
- Observing the patient for verbal and non-verbal evidences of discomfort.
- Allowing the patient to voice their concerns and offering to help them as needed.

Simple actions to help prevent and reduce pain:
-Dim the lights.
-Reposition, offer pillows, blankets or comfort.
-Speak softly and calmly, and avoid unnecessary noise, re-assure.
-Comforting and reassuring verbally.
-Offer to help with hygiene and cleaning as needed.
-Propose distractions such as soft music, TV, or movies.
-Keep the room temperature at a comfortable level.
-Allow the patient to rest, and respect their resting time.
-Educate the patient on who you are and why you are there.

At West Florida Hospital, every employee is part of the "Pain Relief" Team. Report any concerns or observations to the nursing staff to help patients and their family experience a comfortable and pleasant hospital stay. Working together as a team, we can succeed in controlling and managing our patients' pain.

0	1	2	3	4	5
NO HURT	HURTS A LITTLE BIT	HURTS A LITTLE MORE	HURTS EVEN MORE	HURTS A WHOLE LOT	HURTS WORST

HUMAN RESOURCES

Department: Human Resources (VP, HR)	Reference Number: **IV – 48**
Policy Description: **Professional Image**	Page 16 of 159
Approved By: **OPS** (**07/13/11 w/no changes**)	Replaces Policy Dated: 5/21/08; 2/16/06; 6/8/04; 6/18/03; 10/10/01
Effective Date: **3/11/09**	Reviewed w/no chgs: 07/13/11; 05/26/10
Retired:	Last Revised: 03/11/09

SCOPE: All employees of West Florida Healthcare have a direct impact on the image of our facility; therefore, this policy applies to every employee, including contracted or agency personnel.

PURPOSE: West Florida Healthcare has established an image of professionalism and wishes its employees to reinforce this image and ensure a safe and healthy work environment.

POLICY: A key aspect of our image is the outward appearance of our employees. Our outward appearances project our personal values and affects how our customers perceive us.

PROCEDURE: The following standards will be expected from all employees:

EXTERNAL PROJECTION

CLOTHING

The purpose of hospital dress attire and personal appearance standards is to present a professional, fresh and neat appearance to our guests and to assure safe and sanitary working conditions. Personal appearance reflects upon you and West Florida Hospital and indicates your pride and interest in your job. The properly attired individual helps to create a favorable image for the company to the public and fellow employees.

It is recognized that different styles will be necessary depending on changes of seasons, degree of customer contact, the nature of work and safety issues. The final decision on what to wear and what is appropriate apparel is the responsibility of each supervisor or department manager. Supervisors are expected to inform their employees of this policy and to counsel any employee whose appearance is inappropriate for the workplace.

Clothing must be kept neat, clean and appropriate for a professional workplace. Proper attire conveys the image we want to project to our patients, families, visitors and public. Suits and ties are optional based on the day's business needs. Shirts with collars should be worn and buttoned appropriately. Where uniforms are designated, they are to be worn in accordance with department policy. Uniforms should not be altered or changed from the manner in which they were intended to be worn. Inappropriate clothing includes sweatshirts, sweatpants, workout attire, beach attire, tops that show bare midriff and/or back, sun dresses, spaghetti-strap tops, dresses or skirts that are extremely short, sheer or revealing, T-shirts, blue jeans, shorts, tight fitting clothing such as spandex or any other clothing that is provocative or distracting. Hemlines should be no shorter than 2 inches above the knee. Pants should be slacks and length no shorter than **4** inches above the ankle. Clothing should never be revealing.

HAIR

Hairstyles should be moderate to ensure a business-like appearance in a manner that does not interfere with work. Hair must always be clean and neatly trimmed. For safety reasons, long hair should be secured. Extreme hairstyles and colors are not appropriate. Moustaches and beards must be neatly trimmed and moderate in style.

NAILS

Body cleanliness, especially of the hands and fingernails, is a must. Acceptable fingernail length is to be determined by the department manager. Direct care providers must also comply with the provisions of the Infection Control Hand Hygiene Policy, to include no artificial nails.

ACCESSORIES

Jewelry should be simple and not excessive. Body piercing will be limited to 2 pierces per ear lobe. The wearing of jewelry in certain areas may not be allowed for safety reasons. Tattoos should be kept to a minimum, discrete and appropriate for the business environment.

SHOES

In clinical areas closed-toe shoes are required for safety reasons. Open-toed shoes are permitted in non-clinical areas. Open-backed shoes are permitted in both clinical and non-clinical areas. No **flip-flops**.

MAKEUP

Makeup should be used in moderation to enhance a natural appearance. Colors must be soft and understated, without heavy colors or dramatic styles.

PERFUMES/COLOGNES

Due to general customer negative reactions and the risk of severe allergic reactions, the use of strong perfumes, colognes, after-shaves, or other odor-masking chemicals is prohibited.

HYGIENE

Each employee is expected to bathe or shower daily and use an appropriate deodorant to minimize natural body odor. Breath must be clean.

IDENTIFICATION

Hospital identification badges should be worn by all employees while on duty. Badges should be worn on the upper shirt/coat lapel or pocket with the name and picture visible at all times.

internal projection

West Florida Healthcare's mission is to serve our customers. All customers have a basic expectation to be treated with courtesy. We are committed to providing the highest quality of service to our customers and meeting their needs with the utmost care and courtesy. The desire to go beyond what is asked or expected is a gift that rare individuals give their co-workers and their organizations. Many things can be taught but not extra effort. Effort comes not from a book, but from the heart.

It is imperative that every employee must feel a sense of ownership toward his or her job. This is simply taking

pride in what we do, feeling the outcomes of our efforts, and recognizing our work as a reflection of ourselves.

Take pride in your organization as if you owned it.

Look beyond your assigned tasks. Your responsibility does not end where your co-workers' responsibilities begin. In most situations, responsibilities merge and blend. Step "out of the box" when appropriate and perform a task that you may not ordinarily complete (within your qualifications).

Good customer service springs from the individuals that are within the organization. This requires compassion and the rare ability to understand that only by consistently putting the needs of our customers first can we achieve being first as an organization.

Treat all co-workers the way you would like to be treated. We are all linked together with the common goal of serving our patients and our community. Our co-workers are our teammates and our internal customers. Treat everyone as a professional, show consideration, be supportive, praise when appropriate, and be tolerant and cooperative. Be honest, loyal and a valuable asset to your co-workers as well as the hospital as a whole.

Pride is a personal commitment. It is an attitude that separates excellence from mediocrity.

"I treat the other man like a gentleman not because he is, but because I am." – Benjamin Franklin

Smoke-Free Facility Policy Summary

The purpose of our smoke-free policy is to regulate smoking within the facility for the health and safety of our patients, visitors, employees, contract workers, agency personnel, and medical staff members, and to comply with The Joint Commission No-Smoking Policy and the Florida Clean Indoor Air Act. Since we are dedicated to enhancing the overall quality of life and providing a safe and healthy environment, we have adopted the following policy in regard to tobacco and smoking products.

Smoking is prohibited in all enclosed areas and landings of the Hospital, including the Pavilion, the Rehabilitation Institute of West Florida, and the Diagnostic Imaging Center. Smoking areas have been designated outside the hospital for those patients, visitors, employees, contract workers, agency personnel, and medical staff members who feel the need to smoke.

Procedures:
Patients, visitors, employees, contract workers, agency personnel, and medical staff members are prohibited from smoking around all entrances to the facility's buildings and on all sidewalks around the perimeter of the buildings as indicated by no-smoking signs. Smoking is permitted only in designated areas.

By restricting smoking around entrances, it limits the threat of fire to the building and is out of the path of egress into the building, which avoids exposure of second-hand smoke to other patients, visitors, employees, contract workers, agency personnel, and medical staff members.

Smoking Regulations for Patients:
All ambulatory patients desiring to smoke must proceed to the designated smoking areas outside the facility. Hospital staff must be reasonably assured that the patient is oriented, able to ambulate and responsible. A family member or visitor may escort non-ambulatory patients to a designated smoking area. There will be no exceptions made to this policy.

Monitoring Effectiveness:
In order to evaluate compliance with the organization's non-smoking policy, the following will be followed: Security will monitor policy compliance during all rounds. Security will stop all smokers and:

- Inform them of our no-smoking policy and of the designated smoking areas
- Instruct them to extinguish the tobacco product
- If an employee, take identification and forward, by written documentation, to the facility's Safety Officer. The Safety Officer will then notify the appropriate department director for disciplinary action.
- Violations are tracked by the Safety Officer/designee and reported to the Safety Committee.

Education:
Upon orientation, employees are given information on the No Smoking policy and information on agencies and programs that offer help for smokers who desire to quit. West Florida Hospital offers a Freedom From Smoking program for both inpatients and outpatients.

Department: Human Resources (VP, HR)	Reference Number: **IV – 50**
Policy Description: **Attendance and Tardiness**	Page 19 of 159
Approved By: OPS (review with 1 change **07/14/10**)	Replaces Policy Dated: 7/19/07; 6/8/04
Effective Date: **07/14/10**	Replaces Policies: HR.OP.001 and IV-46
Retired:	Prev. Revised Dates: 04/08/09

SCOPE: This policy applies to all employees of West Florida Healthcare.

PURPOSE: To provide clear guidelines for employee attendance and tardiness within FMLA guidelines.

DEFINITIONS:

Absence occurrence: An unscheduled absence from work on one or more consecutively
scheduled workdays which is not a result of an FMLA protected leave.

Tardiness: Arriving late for a scheduled work shift which is not a result of an FML
protected leave. Employees are provided a **7 (seven)** minute grace period in
consideration of unforeseen circumstances and will not be subject to
disciplinary action for tardiness within that grace period.

POLICY:

Each employee is expected to adhere to established work schedules ad to arrive at work in a timely manner. Excessive absenteeism and/or tardiness (6 in a 12 month rolling calendar year or 3 within a 30 calendar day period) may have an adverse effect on an employee's future merit increase, performance appraisal rating, transfer requests, and/or promotional opportunities, and may result in disciplinary action up to and including termination.

Additionally, an employee who demonstrates a pattern of absences/tardiness may receive disciplinary action up to and including termination. Examples of "patterns" include, but are not limited to:

- Trend of absences before or after a regular scheduled day off
- Routine Monday/Friday absences
- Absences in conjunction with holidays
- Absences shortly after an occurrence has dropped off of an employee's record
- Regularly leaving work prior to the end of a scheduled shift

Notification of absence/tardiness

An employee must personally notify his/her immediate supervisor at least two (2) hours before the scheduled start time, unless an unforeseeable emergency prohibits notification. In such case, the employee should contact his/her immediate supervisor at the earliest possible time. If the supervisor cannot be reached, the nearest ranking supervisor may be contacted. Failure to provide appropriate notice may result in the absence being unpaid, and may result in disciplinary action up to and including termination.

Within a 12 month period, if an employee fails to report for 2 scheduled work shifts without notifying an immediate supervisor, it will result in the employee's dismissal.

Employees should contact their Human Resources Department for facility-specific internal operating procedures.

The organization reserves the right to:

- Authorize or refuse to authorize an employee's request to be absent
- Investigate absences
- Determine whether an absence is necessary or justifiable
- Deny pay for an absence in violation of the policy

Perfect attendance is defined as the employee being present to work their entire published and assigned work schedule every scheduled shift for the entire Award year.

Absences limited to schedule changes made by the Department Manager for business operations reasons, mandated military reserve time, jury duty, approved Family and Medical Leave, and *scheduled* PTO only are exempt for this purpose.

All other absences for such reasons as PTO Sick, emergencies and funeral leave may be considered reasonable authorized absences, but they disqualify the person from receipt of this Award during that defined year. This includes last minute PTO requests and leaving work early, even if for good reason.

Eligibility for this Award is extended to all full-time and part-time employees, including Department Managers.

The Award for perfect attendance is 8 hours of PTO for full-time employees and 4 hours of PTO for part-time employees. The PTO will be added to the employee's PTO account balance coinciding with the processing of the performance review. Use of this PTO will be in accordance with regular established pay policy.

PROCEDURE:

Department Manager and Vice President, Human Resources approval is required. Documentation showing perfect attendance must accompany a completed Performance Review Document. The Award PTO hours will be noted in the "Comment" section of the PAF.

Department: Facility Management (COO)	Reference Number: **VII – 08**
Policy Description: **Parking**	Page 21 of 159
Approved By: **OPS (reviewed 05/11/11 with revisions)**	Replaces Policy Dated: 5/21/08; 1/10/07; 4/26/06; 10/26/04; 7/15/94
Effective Date: **05/11/11**	Revised Dates: 5/11/11; 5/19/10; 4/29/09, 5/21/08

SCOPE: All medical staff, employees, and contracted employees of West Florida Healthcare.

PURPOSE: To provide employee parking guidelines.

POLICY: All employees are expected to comply with West Florida Healthcare parking guidelines and assist in making space available for patients and visitors in front of the Hospital building. Employees should never occupy a parking space designated, "Patient/Visitor".

PROCEDURE:

RESTRICTED PARKING AREAS. Employee automobiles should not be parked in front of the Hospital, Rehabilitation Institute, Healthworks or the Pavilion. Although employees are encouraged to use available designated employee parking areas, exceptions will be made when employees or spouses use their car to visit patients in the Hospital. In this case, the

employee/driver should notify Security by calling 4184, or through the PBX switchboard so the vehicle is not ticketed or towed.

Employees must not park in any areas marked "reserved" (i.e. Clergy, Emergency Room, Cardiac Rehabilitation, Physician, etc.). Employees should not park in the yellow restricted zones adjacent to the helicopter pad or in Medical Center Clinic parking, which is adjacent to and just south of Hospital parking. Employees should only park in spaces that are designated **"K" or "L"** on the parking map.

Shuttle bus service by Security may be available during inclement weather from 6:30 a.m. - 9:30 a.m.

EMPLOYEE SPECIAL NEEDS/DISABILITY. Employees requesting special needs parking, or disability parking will need to provide the employee health nurse with medical certification. This certification needs to address the medical situation, special parking requirements, and the duration of the need. Once this has been reviewed, a Special Needs Parking Pass will be issued for the length of time required.

DAY EMPLOYEES (7-3). All West Florida Healthcare day employees are to park in the East Lot across Davis Highway or in the North Lot located north of Johnson Avenue. These are designated **"K"** on the parking map.

EVENING EMPLOYEES (3-11), NIGHT EMPLOYEES (11-7), AND TWELVE-HOUR EMPLOYEES. "Twelve-hour employees" consistently work twelve-hour shifts. All evening, night and 12-hour employees should use the designated **"L"** Lot located west of the Hospital near the West "Hospital Entrance."

VEHICLE LICENSE NUMBER. Employees who park their vehicles on Hospital property must register the current vehicle license plate number with the Security Office by applying for a Hospital parking decal. Once registered, the parking decal must be attached to the rear window of the vehicle in the lower left corner. This enables rapid vehicle identification in case of emergency and other needs. If license plates change, notify the Security Office.

PARKING VIOLATIONS. Parking Violations will follow steps 1 – 4 below:

1. TICKET Warning
2. Wheel Lock – Inconvenience
3. Wheel Lock - $25 fine and Supervisor will be notified
4. Wheel Lock ($25) and Tow Vehicle ($85/day plus $15/day storage plus tax),

Notify
        supervisor

STUDENTS. Students training on the West Florida Healthcare campus will comply with the same parking regulations imposed on hospital staff and employees.

Physician Office Building

K

Cancer Center

K

K

K

H

I

K

N

C

B

L

A

L

N

A

D

E

M

G

F

North Davis Highway

University Parkway

Olive Road
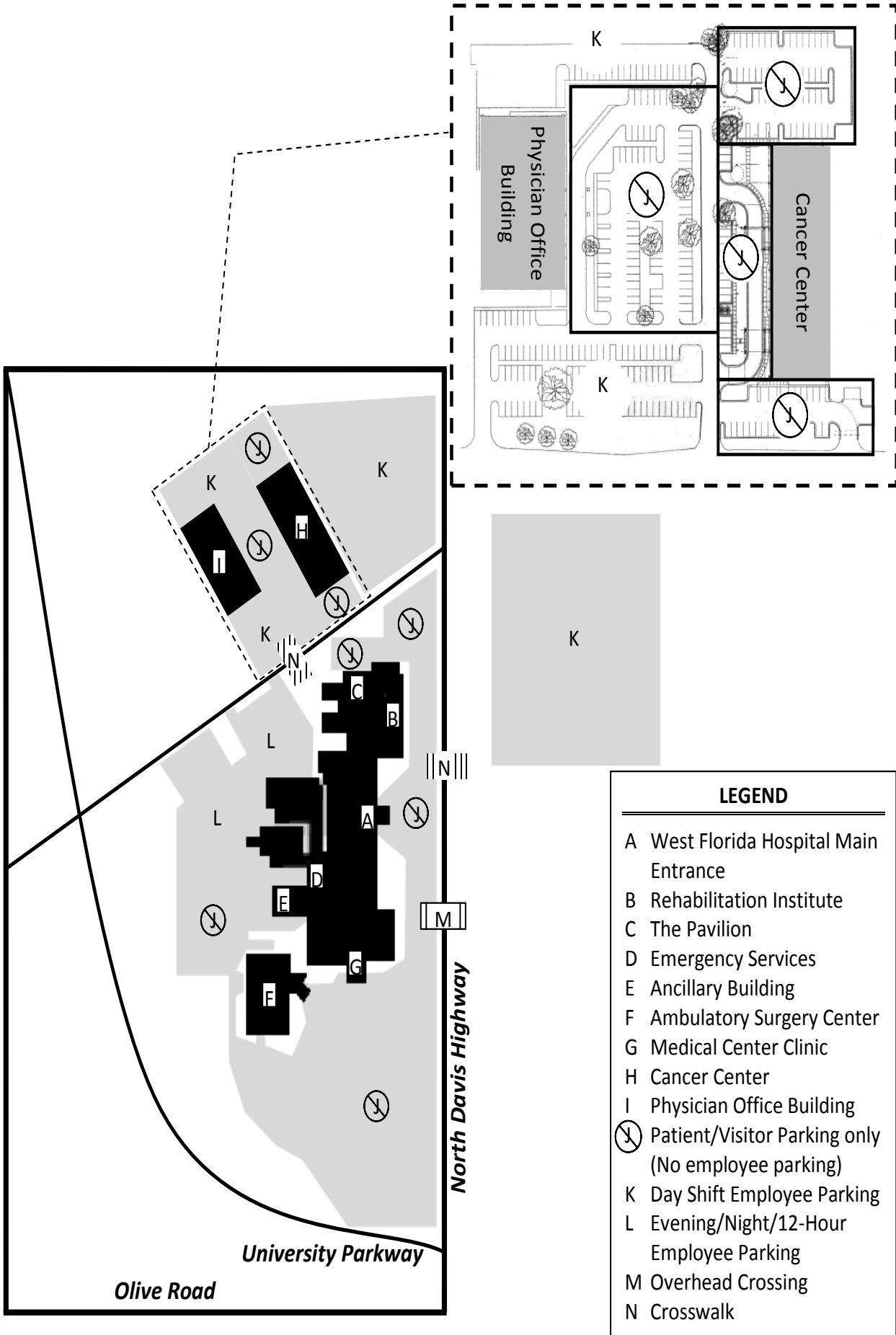
LEGEND

A West Florida Hospital Main Entrance
B Rehabilitation Institute
C The Pavilion
D Emergency Services
E Ancillary Building
F Ambulatory Surgery Center
G Medical Center Clinic
H Cancer Center
I Physician Office Building
Ⓧ Patient/Visitor Parking only (No employee parking)
K Day Shift Employee Parking
L Evening/Night/12-Hour Employee Parking
M Overhead Crossing
N Crosswalk

COMMUNICATION PRIVACY

WFH's
Facility Privacy Officer:

Director,
HEALTH INFORMATION MANAGEMENT
EXT. 6502

HIPAA and HITECH Summary

This summary serves as a review of important Health Insurance Portability and Accountability Act (HIPAA) and HITECH (Health Information Technology for Economic and Clinical Health Act) requirements. Many of these requirements are included in our Code of Conduct, Privacy and Information Security and Ethics and Compliance policies and procedures. All patient information is confidential.

The objectives of the HIPAA and HITECH training are:
- To heighten your awareness of and compliance with HIPAA and HITECH regulations and WFH policies.
- To reinforce the role you play in creating and maintaining organizational integrity, ethics, and compliance.
- To renew your working understanding of HIPAA and HITECH compliance.

Reporting Concerns

There will be no retribution for asking questions, raising concerns about the Code of Conduct or for reporting possible improper conduct that are done in good faith. Any colleague who deliberately makes a false accusation with the purpose of harming or retaliating against another colleague will be subject to punishment.

We encourage the resolution of issues at the local level whenever possible. To obtain guidance on an ethics or compliance issue or to report a potential violation, you may choose from several options.
- Consult your supervisor
- Consult your Facility ECO or another member of management at your facility
- Call the Ethics Line at 1-800-455-1996

The Ethics line is an easy and anonymous way to report possible violations or obtain guidance on an ethics or compliance issue. You are encouraged to use the Line anytime, especially when it is inappropriate or uncomfortable to use one of the other methods. In order to properly investigate reports, it is important to provide enough information about your concern.

Information Security

IDs and Passwords
Patient Financial Information, Clinical Information, and User Passwords are all examples of confidential information. A User ID without a password is not confidential and is frequently included in directories and other tools widely available. The person granting access to a system or application typically assigns a User ID to the end user, and the User ID is sometimes used for identification, tracking and other maintenance procedures within IT&S.
If your have access to information systems, please keep in mind that your password acts as an individual key to our network and to critical patient care and business applications, and it must be kept confidential.

It is part of your job to learn about and practice the many ways that you can help protect the confidentiality, integrity and availability of electronic information assets.

Confidential Information
A patient's diagnosis, the Company's marketing strategy, and computer network configurations are all considered confidential information. The Confidentiality and Security Agreement states that individuals with access to confidential information will not disclose or discuss any confidential information even after termination of their relationship with HCA.

No HCA colleague, affiliated physician, or other healthcare partner has a right to any patient information other than that **necessary to perform his or her job.**

Although you may use confidential information to perform your function, it must not be shared with others unless the individuals have the need to know this information and have agreed to maintain the confidentiality of the information. Patient and confidential information may not be removed from the facility.

Patient or Confidential information should not be sent through our Intranet or the Internet unless Information Systems has put in place appropriate security safeguards. The hospital utilizes encryption software for approved transmissions of protected health information.

Privacy

HIPAA and HITECH regulations set forth a number of requirements regarding ensuring the privacy of protected health information (PHI). Patients are more likely to give honest, accurate information to health care providers, if they believe the information will be kept private.

HIPAA requires healthcare entities to appoint a facility privacy official (FPO). The FPO in our facility oversees the Privacy Program and works to ensure the facility's compliance with the requirements of the HIPAA Standards for the Privacy of Individually Identifiable Health Information and HITECH. The FPO is also responsible for receiving complaints about matters of patient privacy, educating the workforce regarding HIPAA and HITECH, and maintaining policies regarding HIPAA and HITECH compliance.

HIPAA regulations encourage reasonable safeguards be put in place to protect the patient's information from inappropriate uses or disclosures. At WFH, we do not keep records at the patient's bedside.

The HIPAA regulations contain a number of restrictions on the transmission of PHI; however, they do not prevent faxing or mailing health information as long as certain precautions are taken. Reasonable precautions include verifying fax numbers, validating pre-set numbers, and using a cover sheet on all transmissions. The regulations mandate that health information may not be sold by a facility.

Our WFH Notice of Privacy Practices is provided to all patients, posted on our facility's Internet site and the consent form language refers to the notice.

Patients have the right to request access to any health information that has been used to make decisions about their healthcare at our facility. They can also request access to billing information with approval from the FPO or designee. A patient may fill out a request for a copy of their record. Accessing the Meditech System is not an approved method of providing access to PHI.

A patient may request access to the complete designated record set. This record set includes any information that is maintained, collected, used or disseminated by our facility to make decisions about individuals. A copy of the legal medical record and a copy should be provided upon approved request. A patient may be denied access under certain circumstances (e.g. when a person may cause harm to him or herself or others, or when protected by peer review). Our FPO has more information on the right to access.

In order for the HIM department to track releases of patient information, patients (including employees) should be directed to the Health Information Management Release of Information Department for access to any health information.

A patient may request to amend his/her medical record for as long as the record is maintained by the facility. The request for amendment should be made in writing to the facility. Our FPO and the HIM department have more information on the right to amend. While patients have a right to amend their record that does not mean that health information can be deleted from the record. The patient may submit an addendum correcting or offering commentary on the record, but no information may be deleted from the record.

Policies prohibit employees from accessing their own records in Meditech. Employees do not have a "need to know" for the performance of their job. Employees may, however, fill out the appropriate authorization for release of information in HIM and can obtain a copy of their records.

Everyone is responsible for protecting patients' individually identifiable health information. Any piece of paper that has individually identifiable health information on it must be disposed of in appropriate receptacles. The paper must be handled and destroyed securely. The elements that make information individually identifiable include: name, zip or other geographic codes, birth date, admission date, discharge date, date of death, e-mail address, Social Security Number, medical record/account number, health plan id, license number, vehicle identification number and any other unique number or image.

Any member of the workforce with a legitimate need to know to perform their job responsibilities may access a patient's health information. However, the amount of information accessed should be limited to the minimum amount necessary to perform their job responsibilities. Use appropriate and reasonable safeguards when discussing patient information.

Patients who request confidentiality will have a small "c" in front of their name in the directory. No information is to be given out. Patient's are given a 4 digit passcode to give to relatives who may call for information.

The hospital directory or listing of patients used by the PBX operator, information desk or volunteers should contain only patient name, room/location and condition in general terms. Patient diagnosis or procedures should not be released. Patients have the right to opt out of the facility directory Information may not be released on patients that have opted out of the facility directory.

Personal Use of Social Media

HCA and its affiliates respect the right of employees to participate in blogs and use social networking sites during non-working hours and does not discourage self-publishing or self-expression. Employees are expected to follow these guidelines and policies to provide a clear distinction between you as an individual and you as an employee.

- <u>Personal Responsibility</u>. You are personally responsible for your commentary on social media. You can be held personally liable for commentary that is considered defamatory, obscene, proprietary or libelous by any offended party, not just HCA.

- <u>Non-threatening</u>. Employees should not use blogs or social networking sites to harass, threaten, discriminate or defame employees or anyone associated with or doing business with HCA or its affiliates.

- <u>Disclaimer</u>. When you identify yourself as an employee of HCA or an affiliate, some readers may view you as a spokesperson for HCA and/or that affiliate. Because of this possibility, you must state that the views expressed by you through social media are your own and not those of the Company, nor of any organization affiliated or doing business with HCA and/or an affiliate.

- <u>Privileged or Confidential Information</u>. Employees cannot post on personal blogs or other sites the trademark or logo of HCA, its affiliates, or any business with a connection to HCA or its affiliates. Employees cannot post Company-privileged or confidential information, including copyrighted information, Company-issued documents, or patient protected health information.

- <u>Workplace photographs</u>. Employees must follow the Company's policy regarding photos taken in the workplace.

- <u>Advertising</u>. Except as authorized or requested by HCA or an affiliate, employees may not post on personal blogs and social networking sites any advertisements or photographs of Company products, nor sell Company products and services.

- <u>Patient Information</u>. Do not use your personal social media account to discuss or communicate patient information with one of your patients, even if the patient initiated the contact or communication. Always use Company-approved communication methods when communicating with patients about their health or treatment.

<u>Security</u>. Consult the Information Security site on Atlas for social media information security tips

PATIENT SAFETY

Patient Identification

SCOPE: This policy applies to all components of West Florida Healthcare.

PURPOSE: All patients will be properly identified through the Continuum of Care.

POLICY:

1. All patients will be identified on admission by application of appropriate armband. (See Admin. Policy VII-21, Identification of Patients/Employee/Visitor/Vendor)

2. Patient Identification for outpatients will be accomplished through the Admitting/Registration process. All outpatients requiring an H&P or undergoing Sedation Analgesia will receive patient identification armbands.

PROCEDURE:

1. On admission to the nursing unit, the admitting nurse will assure proper identification of patient to include:

   a. Patient is in assigned bed and room.
   b. Correct and legible armband is in place.
   c. Patient's records are correctly labeled.

2. Prior to any intervention/procedure, the identity of the patient will be verified by:

   a. Read name and medical record number on armband.
   b. Ask patient to state first and last name.
   c. If patient unable to state name, verify with family when possible.

3. Whenever the patient care area or caregiver changes, the above steps will be followed to assure proper identification.

4. When a patient is transported to another area of the hospital for a procedure, identify the patient by the person transporting to include:

   a. Enter patient name on unit locator board.
   b. Pick up transport slip and patient record.
   c. Verify patient name and medical record number by armband.
   d. Compare armband with patient name on chart.
   e. Ask patient to state first and last name.
   f. If patient is unable to state name, verify patient identity by family member or patient caregiver on the unit.

5. The receiving area nurse will identify patient name by:
   a. Verify name and medical record number on armband.
   b. Ask patient to state first and last name.

6. Upon return to the patient care unit, patient identification will include:

   a. The nurse caring for patient will be notified by transporter when patient arrives on floor.
   b. Locator board will be updated by transporter.
   c. Nurse on unit will re-assess the patient to include verification of patient identity.

Fall Prevention Program

The following are examples of patients who MAY be at high risk for falls.

One who:
- A. Is incoherent or confused;
- B. Is on medication known to affect mobility, orientation, blood pressure or heart rate.
- **C. Has a history of previous falls;**
- D. Is physically debilitated (i.e., **weakness, unsteady on feet, impaired vision**);
- E. Has a disease that may cause fracture (e.g., metastatic cancer, osteoporosis, arthritis, seizure disorder, etc.);
- F. Has a history of stroke or diseases that may cause falls such as Parkinson's disease.
- G. Is elderly
- H. Exhibits signs of orthostatic hypotension or syncope;
- I. Has a disturbance in equilibrium or vertigo;
- J. Uses assistive devices for mobility such as a cane or walker;
- K. Has decreased mobility or unsteady gate.
- L. Has chronic muscle or joint pain.

PROCEDURE:

1. When a patient is identified as being at "high risk for falls", preventive measures will be initiated to reduce the risk of falls and promote patient safety.
- A. **Place a yellow "eye" sign outside of the patient's room. Yellow is the universal color for falls. The yellow "eye" sign alerts employees that the patient is at high risk for falls.**
- B. **Place a yellow high-risk sticker on the patient's chart**, "High Risk Patient for Falls". EXCEPTION: The Emergency Department is exempt from using chart stickers and High-Risk signs.
- C. Place a yellow armband on the patient.
- D. Keep the bed in its lowest position, except when care is being provided.
- E. Educate the patient and family members about the reasons the patient is considered 'high risk' for falls and the fall prevention measures that will help promote patient safety.
- F. Instruct patient to use call bell and ambulate with assistance only.
- G. Institute patient toileting measures every two hours.
- H. Place needed personal items within reach of the patient.

2. Some patients may be at higher risk for falls because of a history of previous falls or because of having suffered a fall while in the hospital. The nurse will;
- A: Place the **Higher Risk for Falls** sign outside of the patient's room.
- B. Document the date of an in-hospital fall on the patient's yellow Armband.
3. The RN assigned to the patient will determine when a patient is to be taken off High-Risk precautions. The reasons for termination will be documented in the Patient Notes and the Plan of Care will be revised.

All patients could be at risk for falls: Be ready to use Fall Prevention Measures

All employees can assist in Fall Prevention by "Keeping an Eye Out" and intervening or notifying nursing staff of high risk behavior.

PATIENT TRANSPORTATION

SCOPE: This is a hospital-wide transport policy that addresses patient transportation and supplements department specific policies.

PURPOSE: To ensure all patients are safely transported within the hospital or between facilities.

POLICIES:

A.   PERSONNEL TRAINING

Individuals transporting patients (nurses, orderlies, volunteers, etc.) will have basic transportation orientation covering hospital policies and safety practices. New transporters will be required to satisfactorily complete the Transporter Skills **Competency Form**.

B.   SAFETY MEASURES

Patients transported by stretcher will always be within sight of Hospital personnel, have side rails raised, and be transported feet-first.

C.   EMERGENCY SITUATIONS

Any patient in transport experiencing difficulty will be taken to the nearest nurse's station where emergency equipment and additional personnel are available to render assistance.

D.   CRITICAL CARE TRANSPORTS

Monitored patients transported to or from a Critical Care Unit must be monitored during transport unless otherwise ordered by the physician. A nurse will remain with the patient until the appropriate person assumes care of the patient.

E.   PACU

A nurse will accompany the patient transferred from PACU to a patient-care area. The PACU nurse will report to a licensed nurse. (Exception: local anesthesia).

F.   PROGRESSIVE CARE/REMOTE TELE PATIENTS

Telemetry/Remote Tele patients that leave the unit for another department will continue to be monitored by telemetry (unless otherwise ordered by physician).

The telemonitor tech should be notified when a patient is being transported out of their department and upon return.

G.   OBSTETRICAL PATIENTS (OB)

OB patients may be directed to the Labor and Delivery unit (LDRP) for outpatient services (non-stress test, amniocentesis, etc.) and may be transported by the LDRP nurse if patient census allows. Otherwise, Emergency Department personnel may transport. An orderly or volunteer may transport the patient if directed by the Administrative

Assistant/Nursing. OB patients will be transported from the Emergency Department to LDRP by wheelchair if in labor, or suspected of being in labor, unless otherwise requested by the patient. Patients who report possible ruptured membranes and/or bleeding may not ambulate, but must be transported by wheelchair or stretcher.

H.   ENDOSCOPY LAB PATIENTS

Outpatient Endoscopy patients report directly to the Endoscopy Lab from Admitting with transport/escort as needed. Inpatients may be transported by wheelchair or stretcher, based on condition. Endoscopy Lab personnel are responsible for transport arrangements.

I.   PAVILION PATIENTS

Pavilion patients will be transported with or without a nurse at the discretion of the charge nurse. They will be transported/accompanied by nursing staff to occupational/ recreational therapy and for any scheduled out-of-hospital activities. Patients will be accompanied by nursing staff to mandatory Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings out-of-hospital.

J.   DISCHARGE PATIENTS

Patients are not required to be discharged via wheelchair. The discharge nurse will determine the appropriate mode of transportation. ***See* Nursing Service Procedure "Patient Discharge Procedure", Section 1, #56.**

PROCEDURES:

A.   PATIENT ASSESSMENT AND HAND-OFF COMMUNICATIONS

Prior to transportation, the nurse in charge, or his/her designee, will evaluate the patient's condition to determine the transportation needs of the patient. Upon patient pick-up, the transporter will identify the patient's nurse's Spectra link telephone number, which will be placed on the patient's chart. This number will be shared with staff having contact with the patient while off the floor.

B.   MEDICAL RECORDS

The medical record will accompany the patient when transported off-unit for studies/ treatment. (Exception: Emergency Department and Rehabilitation Institute patients transported for therapies within the Rehab facility.)

C.   EQUIPMENT

Patients with the following equipment must be transported with the equipment intact: Patients in continuous traction (stability of the weights and constant traction must be assured), the patient is transported in the traction bed; Patients with intravenous medications controlled by infusion pumps are subject to the Intravenous Therapy Procedures of Nursing Services, Category 1 medications must not be removed from the pump for transport (see Nursing Service Procedure "IV Priority List" for exceptions); and any patient being transported (anywhere) will be provided with same level of oxygen support as they are receiving in their room. If this level of oxygen cannot be provided,

the attending physician must be notified prior to the transport).

D.   LOCATOR RECORD

The locator record will be completed by the <u>person transporting</u> the patient and/or chart to or from the patient care unit or by the <u>person receiving a call</u> from the patient's current location advising them of a change in location. The transporting department is responsible for notifying the unit of the change in location. (Exception: The Emergency Department, the Rehabilitation Institute, and internal movement within Diagnostic Imaging Services. If patients are transported <u>beyond</u> the Rehab facility, the locator record is used.) The transporter is responsible for completing the locator log <u>when taking the patient off the unit, and upon return</u>. The transporter will note on the log who is notified.

E.   ISOLATION

Patients in isolation should not be transported unless it is essential. If transport is necessary, the patient care unit will notify the receiving department of the nature of the isolation prior to the transport. Patients should be instructed as to
how they can assist in maintaining their isolation and protect themselves or others from transmission of infection.

NOTE: Equipment used in transporting patients in isolation must be
        cleaned with a hospital-approved detergent/disinfectant
(phenolic base) or 1:10 bleach solution, if visibly soiled.

Patients will be placed on the transport vehicle upon a clean sheet and covered or wrapped with another clean sheet. Additional barriers (impervious drapes, gowns, etc.) should be used as appropriate. Transport personnel should remove their own protective equipment upon leaving the destination location.

Patients shall wear a disposable mask during transport if on **"<u>Airborne</u>" or "<u>Droplet</u>".**

F.   RESPIRATORY THERAPY

The Respiratory Therapy Department will maintain oxygen therapy for a mechanically ventilated patient during transport.
        (***Exception***: Patients leaving the Operating Room).
They will be available to assist, upon request, transports of any intubated or trached patients. They will provide and set up a bedside transport oxygen cylinder and regulator for units that do not have their own. They will also accompany any patient during transport as deemed necessary by the nurse and assist in transporting patients requiring respiratory support from the heliport to their destination.

Any patient who is on a Bi-Level Pressure device (Bipap) needing to be transported within the facility must have a written order indicating what method of transport is to be used. The physician should prescribe that the patient be placed on an appropriate oxygen

device or be bagged via Bipap mask so that adequate oxygenation is maintained during transport.

Respiratory Therapy will not be responsible to the following areas for transport (except as previously noted):

1. Emergency Department
2. Outpatient Surgery
3. PACU
4. ICU
5. Diagnostic Imaging
6. EKG
7. Nuclear Cardiology
8. Cath Lab
9. Physical Therapy
10. Neurodiagnostics
11. Radiation Therapy
12. Nuclear Medicine
13. Endoscopy
14. Ultrasound
15. CCU
16. CT Scan

REFERENCES: Transportation Safety, Safety Manual.
Safety, Nursing Services Policy Manual.

One Person Assist

Assist per patient's needs. Can patient:

A.) Push up to short sitting, as shown? IF SO, then:

B.) You can help by boosting patient's trunk with your arm: "1-2-3-move."

C.) Support your knee at bed as you shift your weight to rear leg.

Sit to Standing/Assist

Place bed in low position. Transfer belt on patient. Place   your feet
apart for balance. When patient at edge, patient leans   forward and
use side rail for grip.

You are in balance. Spine is supported. Knees are bent   and set to
use your leg power. Patient understands the move and sees   the
destination.

Then on a signal "1-2-3-stand," patient pushes off as your   strong legs
straighten and arms pull up. Give patient room for   balance.
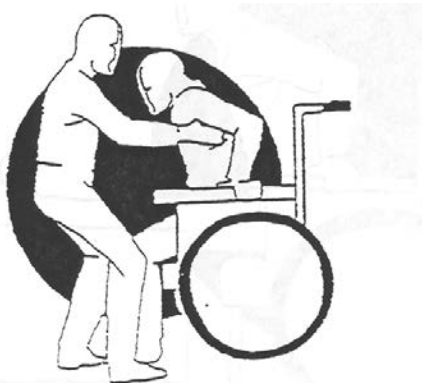Use your knee to   support patient's weak leg, if needed.

Stand to Sitting/Assist

Wheelchair is close to bed. Wheels locked, footrests up. Get set. Then, "1-2-3-move." You pivot as patient steps to chair (on strong leg).

To Sit:

Patient grasps chair arms as you both   slowly squat legs. Stand close,
but give patient room to lean over.

You then assist patient to slide further   back in chair.

Bed to Chair/Sliding

Chair against bed, arm off. Sliding board tucked in   place. On chair
side, support patient's legs against your knees and   patient's trunk
belt to slide patient across board. (If needed,   another helper
steadies board or chair.)
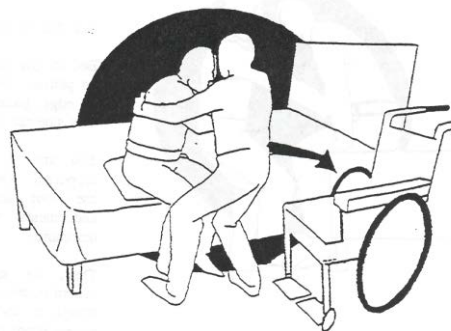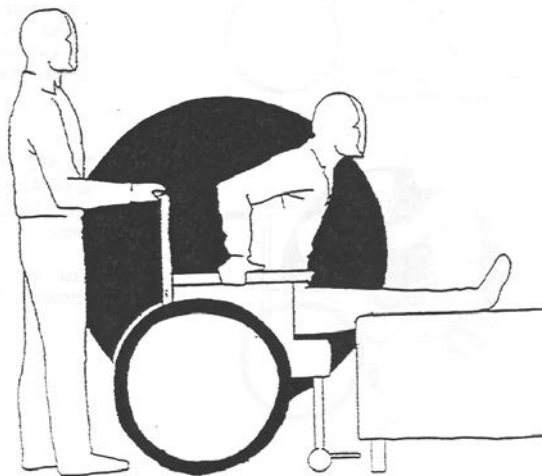
Bed to Chair

(From long-sitting position) You steady chair as patient pushes
back with arms. Also have a second person assisting with the legs
to avoid hyperextension of knees.

Moving to One Side of Bed

If heavy, use 3 persons:
1. Move patient's legs to side and cross arms over stomach
2. Position your hands as shown
3. On signal "1-2-3-pull", pull back as your weight shifts to rear leg (avoid twisting). It is best to use a lift sheet, which is placed under the patient to prevent any shearing action on the patients skin. Roll lift sheet close to patient's side (same position of people and use same pulling technique.)
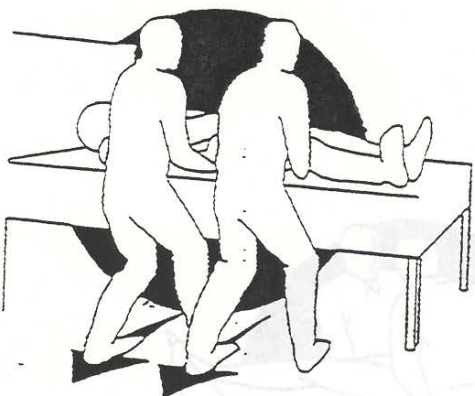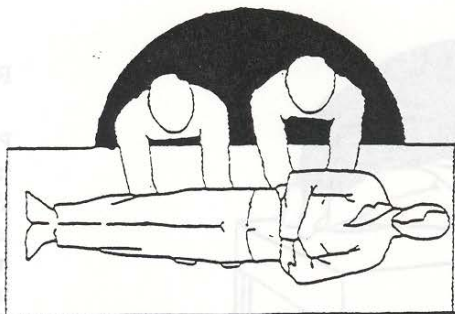
To Head or Foot

If space allows, one person should be on each side of patient. If space does not allow, stand on same side of patient. Use lift sheet again, grasp sheet near shoulders and hips. Front foot points in direction of movement. Have patient assist (if possible) by bending one leg and pushing. "1-2-3-pull." Shift weight to forward foot.

Roll to Side

Position patient to have space when turned; then
1. Move right arm as shown; put left arm across stomach; left leg crossed over right.
2. Helpers alternately grasp shoulders and buttocks
3. "1-2-3-turn." Protect the patient from falling.

Roll to
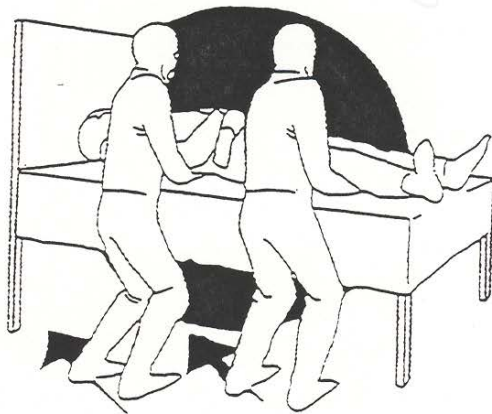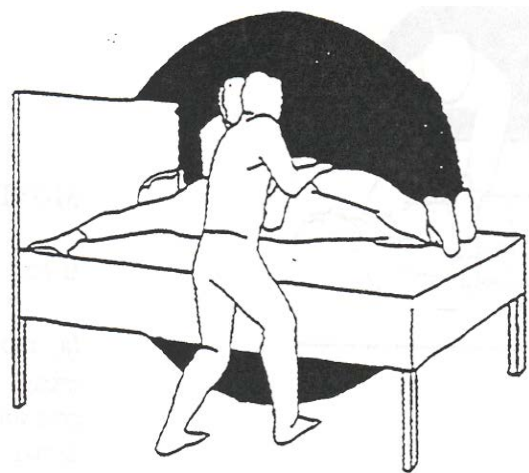
Stomach

1. Move patient to right side of bed
2. Lay patients right arm and leg to the left
3. Helpers alternately grasp right shoulder   and hip
4. "1-2-3-roll."
5. Prevent rolling onto patient's arm, then   slide to center.

Bed to Bed

1. Make sure both beds are locked and adjust heights of bed so they are the same.
2. Have two or three person pulling depending on the size of the patient
3. Move patient to the right and grasp the sheet   as shown.
4. Move patient in two steps.
5. Those pulling should place one or two knees   on the bed you are transferring to, and move patient   to edge of bed.
6. Move one foot back and "1-2-3-pull" and shift   weight to back leg

Supine to Sitting/Passive

1. Turn patient on side. Flex knees as shown.
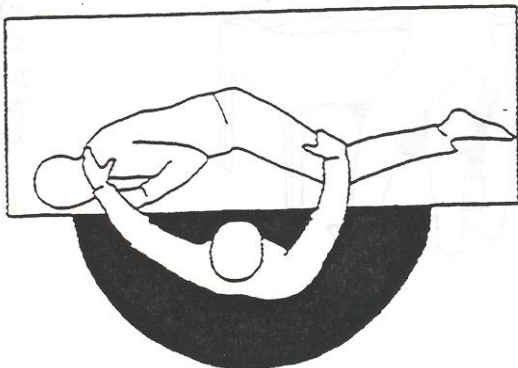
2. One arm reaches over to grasp bottom nee
3. Other arm supports head and shoulders (with your hip against bed)
4. Then "1-2-3-move" in one motion as you shift your weight to rear leg, swing patient's legs over edge whole you pull shoulders to sitting position.

3 Person Lift

Number of
To start, raise
Leader
bed. Grasp

lifters depends on patient's size and disability.
bed to maximum height. Cross patient's arms.
supports heavy parts. Brace your hips against the
patient as shown.
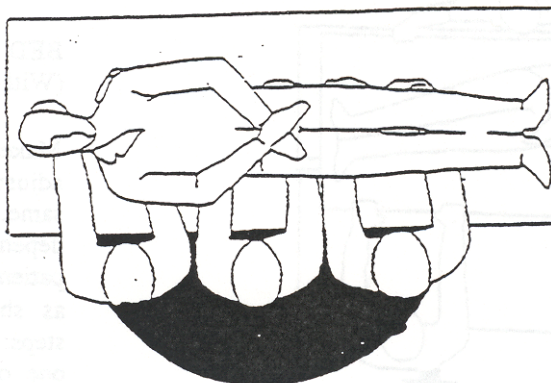
READY: "1-2-3-pull" patient to side of bed
Then roll patient by pivoting elbows on bed as   you bring
patient to ward your chest. Get set and bend your   knees more.
Immediately stand.
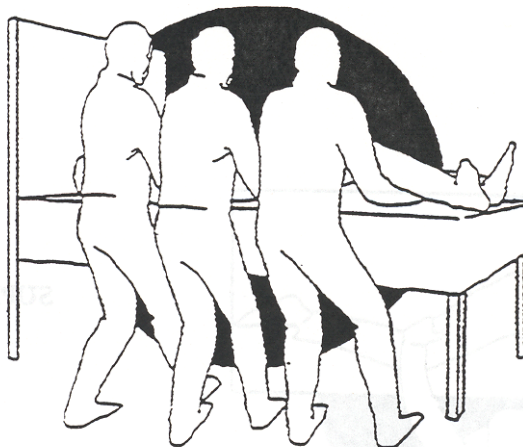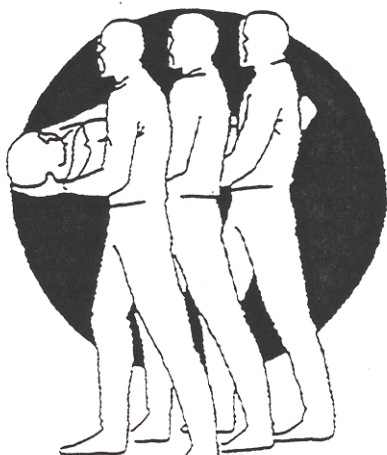
Then: Turn and walk in step (patient on side, held tight against chest) to bed or stretcher.

Now bend knees: "down" onto your elbows and release.

Stretcher Transport

When possible, use two attendants unless patient is conscious and secured with no attachments

Push feet first, side rails up. Patient's arms kept in. Rear wheel swivels locked.
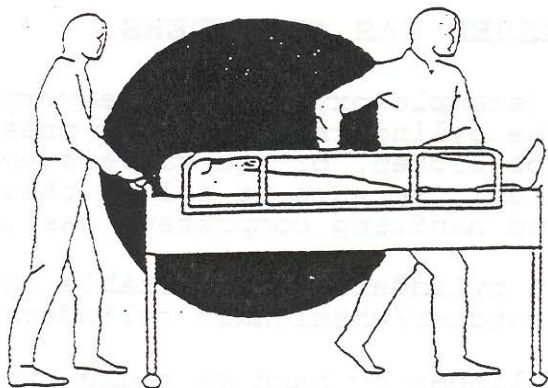
Wheelchair Transporting

Use safety straps as needed. Be sure arms are on lap. Open door, then back chair through. Pull on or off elevators to avoid upset.
Use caution when approaching corners and doorways.
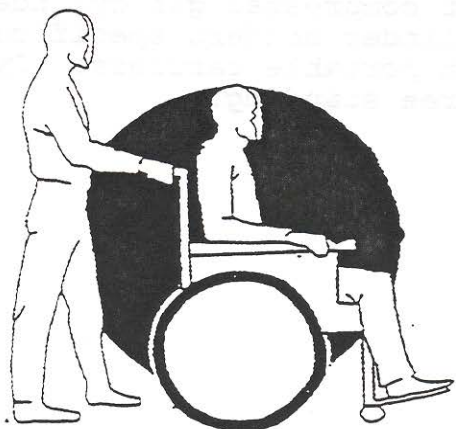
Ambulation

Training is done per physical plan-physical therapy. If helping lesser-disabled patient, know the basic assisting position.

Patient "walks tall" picks up feet. As needed, you support at back close and slightly to weak side. Grasp safety belt; other hand stabilizes shoulder.

I-12
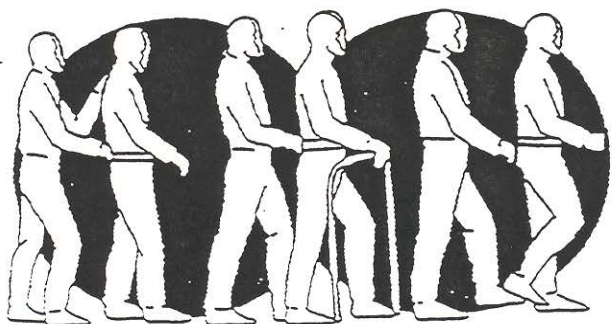
Patients

Restraint/Seclusion
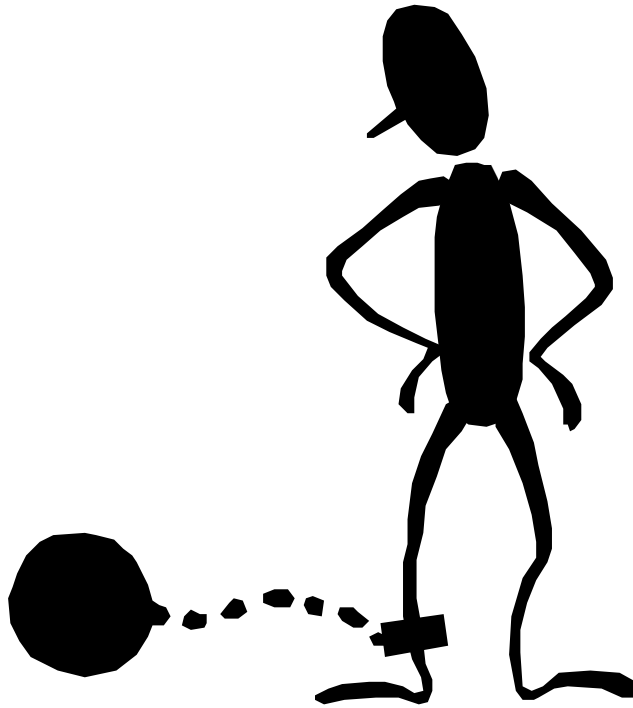
Restraints and Seclusion Policy Summary

The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is decided by a comprehensive individual assessment.

Physical Restraints – any manual method or physical/mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment that the patient cannot easily remove. **Side rails are considered a physical restraint unless specifically requested for use by the patient or when used in the process of transporting the patient from one location to another either by stretcher or by bed.**

Chemical Restraints – drug used as a restraint; a medicine used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

Positioning or Securing Devices - used to maintain the position and/or immobility of a patient during invasive procedures; not considered restraints. Items used during diagnostic or therapeutic treatment that intentionally restrict freedom of movement, under direct observation by the clinician are not considered restraint.

Voluntary Mechanical Support - used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support, not generally considered restraints.

Restrictive Devices Applied by Correction Authority– handcuffs and other restrictive devices applied by correction authority for custody, detention, and public safety reasons and is not involved in the provision of health care; not considered restraints.

Seclusion – is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving and is separated from others.

PROCEDURES:

ASSESSMENT OF RISK FACTORS, INTERVENTIONS AND ALTERNATIVES TO RESTRAINT AND/OR SECLUSION USE

A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. The use of an anatomical, physiological, and psychological assessment for risk factors by the RN and/or the physician facilitates the limited, justified use of restraint and/or seclusion. Planning for, that is, being proactive rather than reacting to, the patient's behavior protects the patient's health and safety and allows for the implementation of preventive strategies that would be of the greatest benefit to the patient.

Prevention of Physical Restraint- Preliminary efforts should be directed to assessing the source of the behavior and take steps to alleviate the problem. Do not overlook simple solutions. Often a patient's behavior can be subdued by addressing their needs (i.e. comfort/pain management, toileting, anxiety.)

LEAST RESTRICTIVE RESTRAINT/SAFE APPLICATION (Listed in the order of the least restrictive)
The types of restraint devices available within this facility, in the order of less restrictive to more restrictive, are as follows:

- **Side rails**
- **Lap Belt**
- **Roll or Soft Belt**
- **Arm splints**

- **Mittens 1→ 2 mitts**
- **Limb Restraints 1 → 2 → 3→ 4 – point**
- **Chemical Restraint**
- **Seclusion**

PROCEDURE FOR USE OF RESTRAINT AND/OR SECLUSION

A physician order must be obtained prior to initiating restraint and/or seclusion. The physician's order must specify:
- The restraint type and/or seclusion,
- The justification for the restraint and/or seclusion,
- Date and time ordered,
- Duration.

An exception to obtaining a physician's order may occur if the physician is unavailable and the patient presents an immediate danger to self or others and all other alternatives and less restrictive interventions have been determined to be ineffective. Prior to the application of restraints, a second tier of review shall occur by a member of nursing management to determine that the patient requires restraint. The trained RN, with established competencies, may initiate the application of a restraint. The physician will be notified of initiation.

Discontinuing Restraint and/or Seclusion Prior to Expiration of the Order

Any patient who is requiring restraint and/or seclusion should be monitored and evaluated for appropriateness of an early release.

PATIENT/FAMILY EDUCATION
Restraint procedures should be performed in a manner that does not violate the patient's rights. Where appropriate, the patient and/or family should assist in the identification of techniques that may help the patient control his/her behavior. The role of the family should be in conjunction with the patient's right to confidentiality.

Before applying restraints, when possible, the patient/family will be provided with an explanation of restraint utilization and the reason for restraints. Unsuccessful interventions and alternatives should also be discussed and input from the patient/family/significant other should be solicited. If no other alternatives/interventions are identified, the RN will explain the restraint policy and how it is applied. The RN will also offer an explanation as the conditions for release. An educational handout is available for restraint patients/families/significant others if further education is needed.

DOCUMENTATION
- Hospital personnel who have been designated to receive training and demonstrate competency will document information related to the use of restraints within the scope of their license. Each episode of restraint/seclusion use is to be recorded in the medical record.

STAFF TRAINING

Hospital staff designated to receive training will be educated upon hire and before they participate in any use of restraints and seclusion, and annually thereafter. Staff will receive education regarding:

- A basic understanding of the underlying causes of harmful behaviors that may be exhibited;
- Understanding that behaviors are sometimes related to medical condition;
- Understanding of how the staff's own behaviors may affect the patients;
- The use of alternative interventions;
- Recognize signs of physical distress the initiation, safe application, and removal of restraints to include monitoring, reassessment, and application and removal.

Management of Suicidal Patients

SCOPE: This policy applies to all patients of West Florida Healthcare, including West Florida Hospital, the Pavilion, and the West Florida Rehabilitation Institute (RIWF).

PURPOSE: To provide guidelines for the management of patients known or suspected to have suicidal thoughts or actions.

POLICY:

1.   A patient known or suspected of being suicidal, either by expression of suicidal thoughts, actual plan, or attempt, will be admitted to the Pavilion by the attending psychiatrist, unless the needs of the patient demand care and/or monitoring not available in the Pavilion. Please refer to the Pavilion Policy Manual for management of suicidal patients admitted to the Pavilion.

2.   Should a patient's condition warrant admission to the acute care facility or RIWF, the following will take place.
   a. Any patient, known or suspected to be suicidal, if not attended by a psychiatrist, will have an urgent consult ordered by the attending or treating physician for psychiatry.

   b. Suicide precautions will be ordered by the attending or treating physician. Behaviors leading to use of suicide precautions should be documented by the physician.

   c. Hourly observations of patient behavior will be performed and documented in the medical record by nursing staff. If changes in the patient's mental condition or behavior are observed, the psychiatrist and/or attending physician will be contacted and interventions will be implemented as ordered.

   d. If it is necessary to transport the patient to another area of the Hospital for any testing or procedures, a staff member must accompany and remain with the patient at all times.

   e. Twenty-four hour sitters will be assigned to the patient unless he/she is under other continuous observation in a critical care unit.

PROCEDURE:

1. Suicide precautions to be implemented include:

   A. A twenty-four hour sitter will be assigned to the patient until an order to discontinue suicide precautions has been obtained from the physician

   B. Search of patient's personal possessions for sharps and other potentially dangerous items, including medication.

   C. Body search (male staff member to have search responsibility for male patients; female

staff member to have search responsibility for female patients).

> D. Removal of all sharps or dangerous objects from room such as razors, hangers, aerosol cans, nail files, scissors, medications.
>
> E. Removal of belts.
>
> F. All beverages to be served in Styrofoam cups rather than cans, bottles, glasses or ceramic cups.
>
> G. Trays to be checked before serving and rechecked after serving for missing objects.
>
> H. Windows to be checked upon admission to assure they are secured.
>
> I. Patient's bathing and shaving are to be supervised.
>
> J. Personnel assigned to care for the patient will not carry scissors, nail files, or other sharp objects in their pockets.
>
> K. Meals to be served on disposable dishes.
>
> L. Personnel assigned to care for the patient will accompany the patient for all procedures off the unit.

2. If patient becomes highly disruptive or agitated, restraints are to be used in accordance with the hospital policy.

3. A Code M may be initiated when additional manpower is required to deal with a patient's behavior. (See Administrative Policy I-23: Codes).

4. The Administrative Assistant/Nursing is to be notified of any known or suspected suicidal patient who has not been admitted to the Pavilion.

Care of Suspected Abuse/Neglect/Exploitation Patients

POLICY:
1. Every staff member of West Florida Hospital has an affirmative duty to report any actual or suspected case of child, disabled adult, elderly or spouse abuse or neglect to the Florida Abuse Hot Line.
2. Anyone participating in making a report of abuse or neglect to HRS shall be presumed to be acting in good faith, and in doing so shall be immune from any liability, civil or criminal charges.
3. No patient/resident or employee of a facility servicing the aged or disabled persons shall be subject to reprisal or discharge because of his/her actions of reporting abuse or neglect.
4. Florida Statutes require mandatory reporting of abuse, neglect or exploitation of a child, aged person or disabled adult.
5. Facility education of abuse/neglect/sexual abuse/exploitation:
   a. All employees will receive education during the hospital orientation program.
   b. All employees will receive annual education while completing their mandatory education requirements for each performance evaluation.
   c. Domestic Violence education is required for all nurses and social workers every two years.

DEFINITIONS.
1. <u>Abused or Neglected Child</u>: a child whose physical or mental health or welfare is harmed, or threatened with harm, by act of omissions of the parent or other person responsible for the child's welfare or for purposes of reporting requirements, by any person.

2. <u>Child Abuse or Neglect</u>: harm or threatened harm to a child's physical or mental health or welfare by the acts or omissions of the parent, adult household member, or other person responsible for the child's welfare, or for purposes of reporting requirements by any person.

3. <u>Child</u>: any person under the age of eighteen (18).

4. <u>Abused Person</u>: any aged person or disabled adult who has been subjected to abuse or whose condition suggests that he/she has been abused.

5. <u>Abuse</u>: the non-accidental infliction of physical or psychological injury to an aged person or disabled adult by a relative, caregiver, or adult household member, or the failure of a caregiver to take reasonable measures to prevent the occurrence of physical or psychological injury to an aged or disabled adult.

6. <u>Aged Person</u>: a person sixty (60) years of age or older who is suffering from the infirmities of aging as manifested by organic brain damage, advanced age or other physical, mental or emotional dysfunctioning to the extent that the person is impaired in his ability to adequately provide for his own care or protection.

7. <u>Caregiver</u>: a person or persons responsible for the care of an aged person or disabled adult; Caregiver includes, but is not limited to, relatives, adult children, parents, neighbors, day care personnel, adult foster home sponsors, personnel of public or private institutions and facilities, nursing homes, adult congregate living facilities, and state institutions.

8. <u>Disabled Adult</u>: a person eighteen (18) years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations which restrict his ability to perform the normal activities of daily living.

9. <u>Exploitation</u> means, but is not limited to, the improper or illegal use or management of an aged person's or disabled adult's funds, assets, or property or the use of an aged person's or disabled adult's power of attorney or guardianship for another's or one's own profit or advantage.

10. <u>Neglect</u>: the failure or omission of the part of the caregiver or aged person or disabled adult to provide the care and services necessary to maintain the physical and mental health of an aged person or disabled adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would deem essential for the well-being of an aged or disabled adult.

11. <u>Medical Neglect</u>: the failure to provide adequate medical care and includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.

12. <u>Withholding of Medically Indicated Treatment</u>: the failure to respond to an infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration and medications) which, in the treating physician's reasonable medical judgment, will be most likely to be effective in improving or correcting all such conditions.

13. <u>Domestic Violence</u>: any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling; or has reasonable cause to believe he or she is about to become the victim of domestic violence.

14. <u>Spouse</u>: a person to whom another person is married or a person to whom another person has been married and from whom such person is now separated or divorced.

15. <u>Family of Household Member</u>: spouses, former spouses, adults related by blood or marriage, persons who are presently residing together as if a family and persons who have a child in common regardless of whether they have been married or have resided together at any time.

16. <u>Sexual Abuse</u>: sexual harassment, coercion or sexual assault.

	Child Abuse	Elder/Adult/Spouse Abuse	Sexual Abuse
Common symptoms to assist in recognition of abuse	♦ Unexplained bruises ♦ Unusual burn ♦ Head injuries in very young infants/children ♦ Abdominal injures ** ♦ Suspicious fractures ♦ Failure to thrive ♦ Injury inconsistent with history	♦ Unexplained bruises: on upper arm, back, torso, groin, breasts, genital area ♦ Unusual burns ♦ Head or facial injuries, black eye, bruised cheek bones, suspicious marks on throat ♦ Abdominal injuries, unexplained discoloration, unusual tenderness, suspicious fractures ♦ Evidence of injuries in several states of healing ♦ Injuries inconsistent with history	• Torn, stained or bloody underwear • Trouble walking or sitting • Pain or itching in the genital area • Bruises or bleeding in the genital area • A sexually transmitted disease
Traits common to the abused person	♦ Cries a lot or too little ♦ Poor eye contact ♦ Wary of physical contact ♦ Quiet and/or withdrawn ♦ Hesitant to discuss nature of injury ♦ No parent separation anxiety	• Poor eye contact • Wary of physical contact • Unusually quite, withdrawn or tearful • Hesitant to discuss nature or circumstances of injury • Unusual nervousness anxiety or self blaming, undeserving • Reluctance of patient spouse/caregiver to allow patient to be interviewed alone	• Have an unusual knowledge of sex or acts seductively • Fear of a particular person • Seems withdrawn or depressed • Gain or lose weight suddenly • Shy away from physical contact • Run away from home

**Most common cause of death from abuse

Reporting suspected abuse:

REMINDER: Florida Statutes require mandatory reporting of abuse, neglect or exploitation of a child, aged person or disabled adult. Any person including, but not limited to, any health care provider or employee as well as many other public servants who knows or has reasonable cause to suspect, that a child/aged person or disabled adult is abused/neglected or exploited, shall report such knowledge or suspicion to the central abuse registry and tracking system on the Florida Abuse Hotline.

The Florida Abuse Hotline can be reached by calling 1-800-962-2873 or by faxing a report to the Florida Abuse Hotline at 1-800-914-0004.

<div align="center">

Procedure at West Florida Hospital

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Any person with knowledge or suspicion of abuse/neglect/sexual abuse or exploitation should report this to the physician, registered nurse, administrative supervisor, department head, and/or case manager.

1. The Nurse Manager or Administrative Assistant of Nursing will conduct an evaluation of suspicion. After conducting the evaluation, the individual whom identified the suspicion, in consultation with the Nurse Manager or Administrative Assistant of Nursing will immediately notify the Florida Abuse Hotline at 1-800-962-2873. The name and badge number of the operator at the abuse hotline will be documented. Information that will be needed when making the report:
   a. Reporter's name/agency/address/phone number/fax number and date. The reporter's name will not be released to any person other than employees of the agency responsible for protective services, the Central Abuse Registry or the appropriate attorney, without the written consent of the person reporting
   b. Victim's name, date of birth/race/sex/address/phone number and for adult victims describe the disability and how the victim is impaired in the ability to care for or protect self

    c. Other household member's name/date of birth/race/sex/relationship to victim

    d. Significant other's name/relationship/address/home phone/work phone

    e. Description of incident: describe the injuries or threat of injuries/date of last incident/how long the maltreatment has occurred/describe concern for protection of victim

    f. Identify others who might be aware of the abuse/neglect or exploitation of the victim, to include: name/address/home phone/work phone.

2. The Case Management Department, or after hours, the Administrative Supervisor will be notified of the report.

3. The Risk Manager and Administrator on Call will be notified of all calls made to the Florida Abuse Hotline.

4. The attending physician will be notified of the findings of the Protective Services investigation.

5. If Protective Services is involved, the patient will not be discharged until the Protective Services gives consent; if the Protective Services request that the patient not be discharged, the Case Management Department will notify the physician, the risk manager, nursing unit, and business office. Documentation will be made in the Progress Notes.

6. Assessment of the patient's physical, as well as emotional appearance shall be documented in the patient's medical records. (Progress Notes or Nursing Assessment Needs) Pertinent statements made by the patient or accompanying individuals shall also be documented.

7. Additional documentation shall include:

    ♦ Consents from the patient, parent, or legal guardian, or compliance with other applicable law;

    ♦ Collecting and safeguarding evidentiary material released by the patient;

    ♦ Legally required notification and release of information to authorities. Including accounting   of disclosure requirements for HIPAA; and

    ♦ Referral s made to private or public community agencies for victims of abuse.

Community Resources:

Abuse Hot Line (Counselor)…………………….	1-800-962-2873
(FAX)…………………………..	1-800-914-0004
(Voice Mail)……………………	1-800-770-0953
Child Abuse Hot Line……………………………	1-800-422-4453
Runaway Hot Line (Florida)……………………..	1-800-786-2929
Favor House Crisis Line…………………………	1-850-434-6600
Favor House Counseling Office…………………	1-850-434-1177
Rape Crisis Center………………………………	1-800-433-7273

STROKE ALERT

West Florida Hospital has long been a leader in stroke care and is certified with the American Heart Association's *Get with the Guidelines*" program and has earned the "*Primary Stroke Center Certification"* from the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission).

Stroke is the third-leading cause of death and is the leading cause of long-term disability in adults in the United States.

A stroke is a medical emergency. Treatment interventions are time sensitive and require quick recognition, assessment and intervention. Patients showing signs and symptoms of a stroke at West Florida are treated with the highest level of priority. Time-sensitive treatments include "clot-dissolving medications" known as t-PA which may prevent or greatly reduce the disabling, long-term effects of stroke. IV t-PA Therapy I s the only FDA approved treatment for ischemic strokes within **3 hours** of symptoms onset. At West Florida Hospital this treatment window was expanded to safely administer IV t-PA up to **4.5 hours** of symptoms onset following the newly revised guidelines from the American Heart/American Stroke Association … Every minute counts! The determination for time of symptom onset is a key point to t-PA administration and can be evaluated by asking the patient or family members for a specific time when the patient was last seen without symptoms.

A "Stroke Alert" may be initiated on a patient exhibiting signs and symptoms in the ED or an in-patient who presents with NEW onset of signs and symptoms. Orders for diagnostic services related to the evaluation of the acute stroke patient will be labeled **"STAT – Stroke Alert"**, to ensure that the requested test is handled with the highest level of priority. Diagnostics (lab, radiology, CT Scan, EKG, etc.) designated as "STAT – Stroke Alert" will be completed with results available to the physician within 45 minutes of receiving the order.

Know the Symptoms of Stroke

Sudden numbness or weakness of the face, arm or leg - especially on one side of the body.

Sudden confusion, trouble speaking or understanding.

Sudden trouble seeing in one or both eyes.

Sudden trouble walking, dizziness, loss of balance or coordination.

Sudden severe headache with no known cause.

If you think someone may be having a stroke, act F.A.S.T. and do this simple test:

Act F.A.S.T.	
Face	Ask the person to smile Does one side of the face droop?
Arms	Ask the person to raise both arms Does one arm drift downward?
Speech	Ask the person to repeat a simple sentence Are the words slurred? Can he/she repeat the sentence correctly?
Time	If the person shows any of these symptoms, time is important Call 911 and get to the nearest Stroke Center or hospital FAST! Every minute counts!

As healthcare providers, it is our responsibility to educate our patients, co-workers, Family members and community about stroke symptoms and the need for immediate evaluation.

HEART ATTACKS (Myocardial Infarctions)

Cardiovascular Disease, including heart attack, is the No.1 cause of death for both men and women in the United States. Each year, about 1.1 million Americans suffer a heart attack, and many heart attacks that result in death occur within 1 hour of the start of symptoms, before the person is ever able to reach the hospital.

West Florida Hospital is dedicated to increase awareness and prevention against heart attacks. Recognizing signs and symptoms of a heart attack, and knowing how to react quickly when a person is affected, is the responsibility of each employee at West Florida Hospital.

Some heart attacks are sudden and intense, like a "movie" heart attack, where the actor clutches his or her chest with pain and falls over. However, many heart attacks start slowly, with mild pain or discomfort, and it might be difficult for some people to recognize their symptoms. Here are some of the signs indicating that someone may be suffering a heart attack:

Chest discomfort.
Most heart attacks involve discomfort in the center of the chest that lasts more than a few minutes, or goes away and comes back. It can feel like uncontrollable pressure, squeezing, fullness or pain.

Discomfort in other areas of the upper body. Symptoms can include pain or discomfort in one or both arms, the back, neck, jaw or stomach.

Shortness of breath. Other symptoms. These may include breaking out in a cold sweat, nausea, or lightheadedness.

Women are less likely than men to believe that they are having a heart attack and more likely to delay seeking emergency treatment. Women may present with different symptoms than the typical chest pain expected with heart attacks; discomfort may come and go, and it may be associated with other common symptoms such as shortness of breath, nausea/vomiting, and back or jaw pain.

Quick response is the best action against heart attacks. Treatment interventions are time sensitive, and patients showing signs and symptoms of a heart attack at West Florida Hospital are treated with the highest level of priority. "Clot-dissolving medications" and other artery opening procedures can reverse a heart attack, but the sooner they are started, the greater the chances for survival and full recovery. To be most effective, they need to be started within 1 hour of the start of heart attack symptoms.

Cardiovascular disease such as heart attacks and strokes can be **PREVENTED.**
It is important to know that some risks factors increase the chances of having a heart attack or a stroke, such as: smoking, high blood pressure, high blood cholesterol, overweight and obesity, physical inactivity, and diabetes

Safe Medical Devices

What is a "medical device?"
Any device or apparatus used to prevent, relieve, or treat a disease or affect the structure or function of the body.
Example: IV infusion pumps, monitors, syringes, pacemakers

What is the purpose of the Safe Medical Device Act of 1990?
The act sets reporting and tracking requirements for the hospital as a device user.
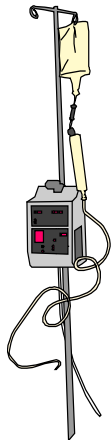
When should a device be reported?
Whenever information suggests that a medical device has or may have caused or contributed to the serious illness, injury, or death of a patient.

How do you report a device that may have harmed the patient?
1. Notify your supervisor
2. Complete an occurrence report
3. Call the Risk Manager and Equipment Safety Officer IMMEDIATELY!
4. Contact Bio-Medical Services

What precautions should be taken with a device, which may have harmed a patient?
1. After contacting Bio-Medical Services, **DO NOT** change any of the settings or any of the components of the device.
2. **ALL** parts of disposable devices must be saved; any wrapping should be retrieved and retained with the device.

Why are certain medical devices tracked in the hospital?
To locate devices and users of the devices immediately in case of a product recall.

Electrical Hazards in a Hospital

INTRODUCTION:
The advent of a tremendous amount of electrical and electronic equipment used for the delivery of patient care in the hospital brings with it the potential risk of exposing patients to electrical shock and hazards resulting from faulty equipment. To ensure safety in the delivery of care to patients, we must have a basic understanding of electrical safety.

ELECTRICALLY SUSCEPTIBLE PATIENTS:
      The following constitute patient who can be very vulnerable to electric shock:

1. Debilitated patients: These patients, due to medical condition, develop a low physical resistance.
2. Patients who have had a major loss of skin resistance due to wet dressings or sweating: When the skin is wet, resistance is reduced and current flows more easily through a wet surface.
3. Patients with indwelling conductive catheters with externally exposed intercardiac leads: Conductive catheters such as pacemakers wires serve as a direct pathway to the heart and can easily carry minute amounts of current.
4. Patients with electrolyte imbalances: Hypersensitivity of the nervous system can result due to electrolyte changes and can therefore increase susceptibility to shock.
5. Patients with abraded skin or skin punctures: The natural resistance is lowered making these patients more vulnerable to shock. The skin provides for an external path for the flow of current and diverts current away from the internal organs. This capacity is reduced in these groups of patients.

COMMON ELECTRICAL HAZARDS FOUND IN A HOSPITAL:
      The less sophisticated electrical devices found in a hospital are common sources of electrical hazards.

1. Bulbs: These can be particularly hazardous when a bigger watt bulb on a lamp is substituted for the size recommended by the manufacturer.
2. Power Cords: Fraying could result from incorrect handling such as yanking cords from outlets. Handling power cords with damp or wet hands is very dangerous. Also, dragging cords over a wet surface when they are not designed for exposure to wet areas can be just as hazardous.
3. K-Pad: Overheating resulting in burns to the patient is a hazard encountered with the use of K-Pads.

Ways of Eliminating or Preventing Electrical Hazards

1. Use common ground
2. Periodic leakage current checks
3. Regular checks of seldom used equipment
4. Use of 3-prong plugs
        If a plug is damaged, label it and send it for repair
5. Prevent use of "cheater" adapters
6. Refer all malfunctioning equipment to Plant Ops (ext. 4888)
7. **Have Plant Ops check out all new equipment prior to use**
8. Discourage use of extension cords, unless they are hospital approved extension cords.
9. Do not simultaneously touch electrical equipment and patient
10. Tag all faulty equipment
11. Know how to operate equipment prior to use
12. Dry hands adequately before handling any electrical equipment

PREPARATION IN THE EVENT OF POWER FAILURE:

1. Know the location of red emergency outlets.
2. Know how to manually operate equipment in the event of power failure.
    Remember: Emergency outlets should not be used for equipment such as vacuum cleaners, office machines, etc. They are intended to be used only for life-sustaining equipment.
3. Know how to install batteries in equipment that can be run by battery.
4. Alkaline batteries can be disposed of in general trash. Lithium batteries must be collected and sent out for disposal. Do not throw in trash can.
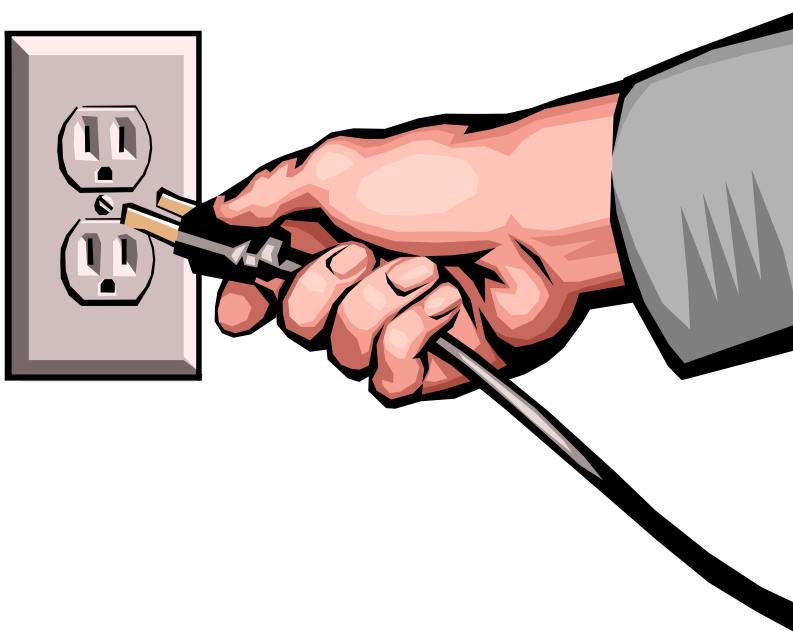
EMERGENCY MANAGEMENT
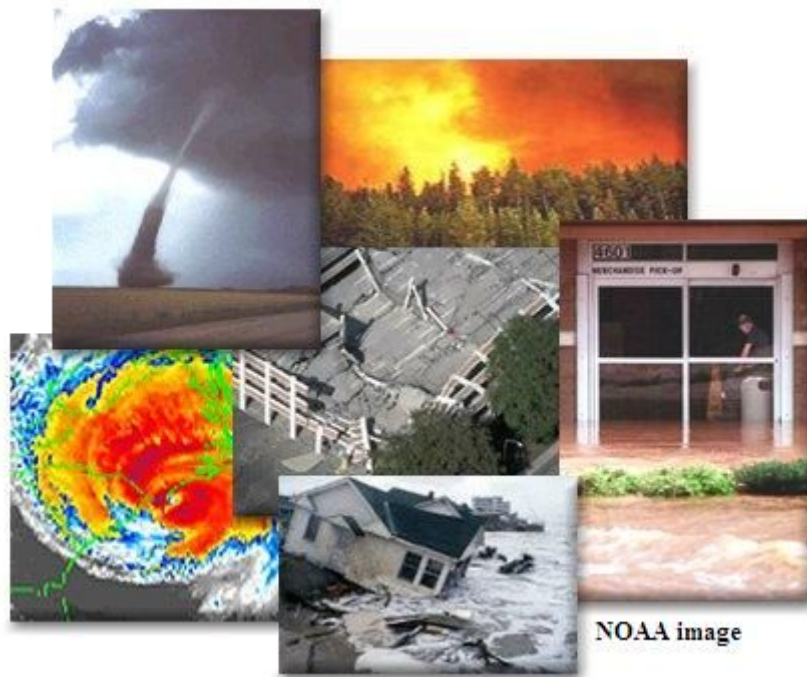
NOAA image

EMERGENCY MANAGEMENT PLAN

When disaster strikes, the community counts upon West Florida Hospital to react in an organized and effective manner. Our Emergency response depends upon two (2) main factors: (1) the Hospital must have a thorough, flexible plan for handling mass casualties; and (2) knowledgeable employees who are fully acquainted with their responsibilities under the Plan. The Safety Committee and Hospital management make continuous improvements utilizing feedback from all customers, aware that the community is depending on us to act quickly, efficiently, cooperatively and unselfishly. Our Readiness Plans for all disasters are updated frequently.

Our Plan is linked to the Escambia County Emergency Management Plan to enhance planning and preparedness. It has been reviewed and approved by local agencies. We are a participant in the National Disaster Medical System Plan.

DEFINITIONS:
- **EXTERNAL DISASTER**. Any event occurring outside the Hospital resulting in injury to a large number of people. External disasters may include fire, flood, hurricane, explosion, car accidents, airplane accidents, train accidents, hazardous waste spills, and Nuclear, Biological, or Chemical (NBC) events.
- **INTERNAL DISASTER**. Any event occurring inside the Hospital resulting in injury to a large number of people, necessitating total or partial evacuation of the Hospital. Internal disasters may include fire, flood, tornado, hurricane, etc.
- **EXTERNAL THREATS**. May include civil disturbances, strikes and bomb threats necessitating precautionary security and/or evacuation, alerts and notification to the staff and/or acquisition of reserve equipment and supplies.
- **FIRE PLAN**. Addresses the use and function of the fire detection and alarm systems, containment and extinguishing, the protection of lives, including transfer of patients and personnel to areas of refuge, and evacuation plans. The Fire Plan also requires each shift to have staff trained in the use of non-automated components of the fire safety system, and a quarterly fire exercise (drill) for each shift to assess equipment and staff readiness and take corrective action as necessary.

When a disaster occurs, a **Code Green** will be called. Staff will be informed of how they will be notified by their specific departments. The severity of the **Code Green** will vary according to the estimated number of casualties and will be classified under one of the following conditions:

> *CONDITION I   (up to 15 casualties)
> *CONDITION II   (estimated 16-30 casualties)
> *CONDITION III   (estimated 31 or more casualties)

The severity of the disaster will determine how many and which personnel will be recalled to the hospital. If the Situation is serious enough, Marketing will call the radio and television stations and ask them to announce on the air:

> "THIS IS A SPECIAL EMERGENCY RECALL NOTICE TO ALL
> EMPLOYEES OF WEST FLORIDA HOSPITAL. EMPLOYEES ARE
> REQUESTED TO REPORT TO WORK IMMEDIATELY. DO NOT ATTEMPT
> TO TELEPHONE THE HOSPITAL

All employees are expected to be available, if needed, should a disaster occur. This is a basic condition of employment. All off-duty employees, including those scheduled for education days, should be prepared to return to the Hospital if contacted. When employees call the Hospital in a

disaster recall situation, he/she should **call the department directly**. The PBX Operators are busy with urgent telephone traffic and should not be overloaded by employee calls when these can be made directly to the department.

The **Disaster Call-Back Personal Checklist** will be given to employees by the department coinciding with disaster recall.

Staff recalled and retained on campus during a disaster will be housed in assigned available Nursing Unit space and other assigned vacant rooms.

All Department Heads will maintain a departmental disaster plan (including maintaining a current call-back list) detailing the department's responsibilities in the event of a disaster. This department-specific plan is kept in the respective departments.

Departments are responsible for identifying sleeping areas for their employees within the department. Vacant patient rooms are reserved for nursing service and members of the Medical Staff, and sleeping accommodation assignments are coordinated by the Chief Nursing Officer.

DISASTER TREATMENT AREAS

Patient Receiving Area - All patients, including patients arriving from an evacuated hospital, will be processed through the Trauma Center, unless otherwise specified in each case.

Triage - The ambulance entrance corridor is designated as the Triage Area for external disasters. Hospital personnel responsible for transporting casualties will bring them to this area.

Immediate Treatment Area - The primary treatment area for casualties is the ED. All immediate patients will be moved to this area. Once proper staffing levels have been reached, the ED Physician may send immediate patients to the Surgery Department.

Delayed Treatment Area - The ED Lobby is designated the Delayed Treatment and Minor Holding Area. Nursing Services will provide nursing personnel as required to provide minor first aid and to be alert to signs and symptoms of more serious problems.

Decontamination Area - Casualties from an accident involving exposure to materials that necessitate patient decontamination prior to treatment will be brought into the Hospital through the Decontamination Room entrance. Decontamination will be conducted in the Decontamination Room, in accordance with Hospital policy and in compliance with regulatory agency guidance.

The following steps should be taken whenever a patient presents to WFH as a victim of a suspected chemical or bioterrorism event:

1.   Call 911 (within WFH call 4111 and instruct the operator to call a Code Orange and then the WFH Biohazmat Team will call 911)
2.   If the patient is carrying a letter or object, ask him to walk outside with the object. The Employees managing the situation should wear PPE (mask, gown and gloves), carry two biohazardous (orange) waste bags and accompany the patient outside.
3.   The patient should be taken to the Emergency Department for decontamination.
4.   Ask the patient to gently place the object into the biohazardous bag. Double bag with the second red bag, and tape securely closed.
5.   If the patient's clothing has been contaminated with the suspected substance, have patient remove clothing and shower. Double bag the soiled clothing, seal, and label.

Visitors & Families - Visitors and families of disaster victims or Hospital personnel will be directed to and will remain in the Hospital Cafeteria.

Employee Children Identification - Children of employees will be identified by wrist bracelets with the child's name, parent's name, and parent's department. This may be applied in any recall situation.

EMERGENCY SUPPLIES

Power. In the event of a Gulf Power electric utility power failure, the generators will come on and assume the emergency loads of the Hospital, Ancillary Building, Pavilion, and the Rehabilitation Institute in less than 10 seconds. Emergency power will be available through red outlets and emergency lighting will be available in all corridors. O.R., ICU, Open Heart and hospital and ancillary elevators will be on emergency power.

Water Supply. In the event that the facility's water supply is interrupted or rendered unusable, an alternate supply will be available. Back up is well water and bottled water.

Communications. In the event that all telephone communications are lost in the facility, Plant Operations, will have direct radio communications with the Escambia County Emergency Operations Center, as well as communication with areas outside Pensacola, if required. Internal communications will be available by hand-held radios from Plant Operations.

Supplies & Drugs. The hospital has contracts with a variety of vendors to obtain supplies in case of a disaster: Medical supplies, oxygen, linen, food, water, drugs, emergency power.

Disaster Fact Sheet Review

What is the code for a disaster?
"Code Green"

What is meant by the "scope" of the disaster?
The "scope" of the disaster indicates the estimated number of casualties involved in the disaster. For example:

    CONDITION 1   0 – 15 casualties estimated
    CONDITION 2   16 – 30 Casualties estimated
    CONDITION 3   more than 30 casualties estimated
The operator will announce the following over the intercom:
    "Code Green, Condition _____"

Does everyone return to work during a disaster?
Each department has a plan for recalling employees to work
in the event of a disaster. Please make certain that your telephone number is correct. If a recall is initiated and you are called, return to work and prepare to stay.
**Wear your uniform and your employee KRONUS badge.
      (Your badge is used as identification)
      NURSES – bring your stethoscope

Where should you report to if called in to work?
See your department's disaster plan. It will tell you where to report and what your duties will most likely be. Some departments will have specific instructions on recorded phone audix.

Should you call the hospital to see if you need to come in to work?
NO!! DO NOT CALL THE OPERATOR!!!

CODE POLICIES

CODES

Please Note: Some sections have changed from alpha letters to numbers

SCOPE: All personnel in the acute care hospital, Pavilion, Rehabilitation Center, Ancillary Building, Medical Center Clinic, and all hospital grounds.

PURPOSE: To define and clarify all emergency codes for the facility.

POLICIES:

I.   ANNOUNCED CODES: These codes will be announced by overhead page and beeper notification.

   A. ***"Rapid Response Team"*** is to bring critical care expertise to the bedside before a crisis situation develops.

      Purpose: The purpose of a Rapid Response Team is to bring critical care expertise to the bedside before a crisis situation develops

      Activation:

      1. In addition to notifying the patient's physician of the acute change in patient status, the RRT can be activated by the staff nurse after collaboration with the charge nurse.
      2. Call 411 to overhead page "Rapid Response Team" to the unit.
      3. Initiate the RRT record, found on the crash carts.

      Team Members:

      The Rapid Response Team is composed of the House Supervisor, a critical care nurse, a respiratory therapist and the patient's primary or charge nurse.

      Examples to Activate the Rapid Response Team

      1. Acute change in heart rate or blood pressure
      2. Sudden respiratory distress
      3. Acute alteration in neurological status
      4. New or prolonged seizures
      5. Severe/crushing chest pain

      (For complete policy/procedure see Policy #8 – WFH Nursing Policies, Section 1, Nursing Services, #23 Rapid Response Team).

   B.   ***"Code 3/Code Blue/Pediatric"*** is an emergency communication alerting trained personnel that a respiratory and/or cardiac arrest has been recognized and that cardiopulmonary

resuscitation (CPR) has been initiated.

1. Critical Care Emergency Protocol will be in effect. The nurse may conduct the code up to his/her level of preparation and job description in the absence of the physician.
2. The nurse in charge will assure that the attending (and consulting) physicians are notified immediately of a patient coding.
3. In the absence of a physician, an ACLS R.N. will run the code.
4. Defibrillation may be performed by a Physician or a qualified R.N.
5. In the Rehabilitation Institute, personnel from OT and PT will provide the crash cart for codes that occur in the First Floor of Rehab, up to the location of the Chapel. Rehabilitation personnel will be at the door to direct those individuals who respond to the code to the correct treatment areas. During Therapy Department operational hours (8:00 a.m. through 4:30 p.m., Monday through Friday, excluding holidays) the PT/OT Staff will be responsible for bringing the crash cart to any Code 3 on the First Floor of Rehab, up to the location of the Chapel. Staff should notify the appropriate nursing unit to obtain the patient's chart. A key to the crash cart storage area (PT and OT Gym) will be kept on the narcotic key ring of both units to be used by either of the Rehab charge nurses in obtaining the first floor crash cart after hours or on weekends.
6. In the Pavilion, personnel on the Adult Unit will provide the crash cart for codes that occur in the Pavilion cafeteria or Pavilion lobby area up to the locked doors (i.e. Xerox room).
7. Whenever a crash cart is utilized for any reason, except in-services, all forms must be completed.
8. The Emergency Department will provide the crash cart for codes that occur on the first floor of the hospital, up to and including the Chapel, Sleep Lab, and the Ancillary Building, as well as for all Pediatric Code 3's.
9. A critical care emergency department nurse is to remain with the patient until transferred to a critical care unit when possible.
10. Satellite facilities not located in the Primary Building. In the event of Code 3 situation, the personnel will provide CPR and notify EMS (call 911) to transport the person to the Emergency Department.
11. An AED will be utilized by first responders in public areas where crash carts are not readily available in the Hospital (i.e. lobby areas, cafeteria, etc.)

Initiation of Codes

1. Personnel in the Ancillary Department, Acute Care Hospital, Pavilion, Rehabilitation Institute and Hospice will initiate a Code 3 by dialing 4111 and stating:
   a. "Code 3," or "Pediatric Code 3" (if patient is 0-12 years of age);
   b. "Appropriate area" or "Room Number."
2. ICU, CCU, OH personnel will either press the Code 3 button at the patient's bedside or dial 4111 if the operator does not announce the code immediately.
3. MCC personnel will initiate a Code 3 by dialing 3488 on the Clinic phones, which alerts both MCC operator and WFH operators that a Code 3 situation exists and stating:
   a. "Code 3," or Pediatric Code 3" (if a patient is 0-12);

    b. "Appropriate area" or "floor" in the Medical Center Clinic. MCC departments will call 911 simultaneously to activate EMS.

4. In the areas such as OR, PACU and where personnel are readily available for code situations, the staff may summon them verbally.

Announcing Codes (PBX)

1. <u>Code 3</u>: After notification, PBX will immediately open-page six (6) times the following statement: "Code 3 _____" (stating the appropriate area and/or room number).
2. <u>Pediatric Codes</u>: PBX Operator will open-page six (6) times the following statement: "Pediatric Code 3 _____" (stating the appropriate area and/or room number).
3. <u>Code Blue</u>: In the event the ED physician cannot answer a Code 3, the Emergency Department will notify the operator. The operator will then open-page, "Code Blue _____" (stating the appropriate area/or room number)**.**

Cancellation of a Code 3/Code Blue

1. If a code button is pressed in error or a code is canceled, dial 4111, identify yourself and unit, and ask the operator to cancel the code.
2. When a Code 3/Code Blue is canceled, the operator will open-page six (6) times the following statement: "Code 3 Clear."
3. Code 3 resuscitation, once in progress, may be terminated at the discretion of the physician.

Role of Emergency Department

1. The ED physician and/or ED nurse, when possible, will respond to a Code 3.
2. When an ED physician cannot attend the code, the nurse in charge of the Emergency Department will notify the PBX to call a "Code Blue."
3. If a Pediatric Code 3 is called, the ED physician and the ED R.N. will take the pediatric crash cart to the code. Respiratory Therapy will bring the pediatric ambu bag. Broselow Tapes are available on each pediatric crash cart. An ED nurse <u>will always</u> respond to a Pediatric Code 3.

Personnel to Respond to Code 3/Code Blue

1. Emergency Department physicians, when available or any available physician
2. Anesthesia personnel, when available, as needed
3. Administrative Assistant/Nursing.
4. Unit Nursing Staff/Charge Nurse/Patient Care Nurse/Other Unit Staff, as needed
5. ED nurse, ACLS certified (staffing permitting).
6. CCU and ICU nurse, ACLS certified (staffing permitting).
7. EKG technician
8. Respiratory Therapy Technician
9. Laboratory Phlebotomist
10. Chaplain. (When available)

Management of Code 3/Code Blue

1. The first responder will initiate the Code 3 by calling the operator at 4111 or push Code 3 button if available. (Confirm correct room number with operator).
2. Place patient in supine position.
3. Use ambu bag for breathing and initiate BCLS measures.
4. The crash cart with defibrillator will be brought to the appropriate room or area.
5. The patient will be placed on the monitor and ACLS measures performed as qualified staff arrive.
6. Critical care emergency protocol will be in effect.

Pediatric Patients

When a unit admits a pediatric patient, they will notify Supply Chain in order to obtain a pediatric ambu bag and intubation tray, which will be kept on the unit until patient is discharged.

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NURSE ALERT: VENTRICULAR FIBRILLATION IS RELATIVELY UNCOMMON

IN INFANTS. THERAPY SHOULD FIRST BE DIRECTED TOWARD ADEQUATE VENTILATION AND OXYGENATION, MAINTENANCE OF CIRCULATION AND CORRECTION OF ACIDOSIS WHEN AN INFANT OR CHILD IS FOUND PULSELESS.

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Patients in Isolation.

1. A "Code 3" called for patients in isolation is conducted as any other code with the exception of the following:

   a. Persons entering the room will comply with the requirements of the specific isolation category.
   b. Disposable equipment will be red bagged and discarded per isolation procedure.
   c. Crash cart will be returned to CSR for reprocessing and restocking.

Code 3 Review Form.
1. A "Code 3" record (#93) will be used during all codes and will become a permanent part of the patient's chart, negating the need for documentation in the medication administration record and physician's order sheet. The "Code 3" record should include the following:
   a. Stamp record with sticker or write in name, age and attending physician.

   b. The time the arrest was called, date and location – information must be completed on every record, i.e., x-ray room 1 or 4-North – 405.
   c. Ventilation – Note time started, types of ventilation and by whom. If intubation
      was done nasally, it should be recorded as such. Record name of person who was intubated.

d. External massage – document time started.

e. Persons responding – record NAMES of people responding to the Code 3. If possible, give department names, i.e., Jim Jones, Respiratory therapy. Do not list department name only.

f. Blood gases -- note times when blood gases are drawn.

g. EKG -- check yes or no

h. Code Blue -- check yes or no.

i. Medication -- record all medications given indicating name and strength (when indicated), dose, route (IV or intra cardiac) and time. The divided lines are for the recording of different dosages of the same medication.

   EXAMPLE:

	Time	Amount
Xylocaine IV	10:00	100 mg

   All medications drawn up, but not used, must be listed on the Code 3 record and "wasted" written after the name of the drug.

   Any medication which is acquired from unit stock drugs must have "unit stock" written after the drug name.

j. Solutions: Record all solutions given per IV infusion, i.e., D5W 250cc.

k. Indicate any medication put in dilution, i.e., Dopamine, Isuprel and note amount of drug in solution. Record time started and stopped and the amount absorbed, Note LTC. Any solution made up, but not used must be indicated using the work "wasted" after the solution.

l. Defibrillation - the time and joules are to be recorded on the Code 3 form each time the procedure is done.

m. Time, pulse - the patient's condition at intervals should be recorded with regard to BP, pulse or rhythm in the nurses note section and/or any other space provided.

NURSE ALERT: **If patient has a latex allergy, pop the top off any rubber vials prior to use.**

Completion of Code 3

1. In the "Outcome of Code 3" Section check one of the boxes at the bottom of the form to indicate if code was successful or unsuccessful and (if applicable) if patient was transferred to another unit. The physician will sign the record or if none present, the nurse conducting the code will sign the record.

2. The nurse completing the Code 3 record signs their name at the bottom left side of the Code 3 record at the area titled, "Nurse Completing Record" and documents in the "Patient's Progress Notes" patient assessment preceding the code, the time of initiation of the Code 3 procedure and the time of termination of the Code 3 procedure

3. The white original is placed on the patient's chart in front of the Daily Nursing Record. The yellow bottom portion, Code 3 Record/Review portion, will be completed to identify any problems with supplies, medications, equipment or personnel. The carbon of the Code 3 Record/Review and the stickered miscellaneous charge voucher are sent to Supply Chain with the used crash cart. Supply will be responsible for bringing a new cart to the unit and for sending the cart and forms to Pharmacy for medication replacement and locking of the cart.

Integrity of Crash Carts and Emergency Equipment

1. The Pharmacy department maintains responsibility for the integrity and security of medications on emergency carts. Pharmacy will assure that medications on crash carts are in date. If any cart is opened for any reason, Pharmacy will check the contents of that cart and secure it with a lock prior to it being made available again for use. Pharmacy will store all the locks used for emergency carts.
2. Supply Chain maintains responsibility for the integrity of supplies stored on each Cart.
3. Drugs placed on emergency carts are approved by the Pharmacy & Therapeutics Committee. A list will be made available on the clipboard on each crash cart.
4. An emergency cart will be accessible in each patient care area, with backup carts store in Supply Chain. A Pediatric Crash Cart will reside in the Emergency Room, OR area, and PACU, with a backup in Supply Chain.
5. Medications are stored in a plastic tray in the fifth drawer of each cart. The tray will be secured with a "green" plastic lock. The entire cart will be secured with a chain and a "green" plastic lock. Each tray will contain plastic red locks to secure the tray and cart after being opened.
6. Each emergency cart and each medication tray within each cart has a unique number for tracking purposes. Supply Chain will maintain a log of carts re-supplied, the current location, and expiration dates of supplies maintained on each cart. Pharmacy will maintain a log that contains a page for each tray that documents the cart number in which the tray resides and the expiration date of each item for that tray. Each cart will bear a label displaying the expiration date of the first medication and supply to expire on that cart.

Procedure

1. Following a "Code 3," or at any time the integrity of the cart is broken, a plastic lock will be <u>replaced</u> from the medication tray to secure the medication tray, and a plastic lock is <u>replaced</u> to secure the entire cart for transport;
2. Supply Chain personnel will be notified and will exchange the opened cart with a stocked cart;
3. Supply Chain personnel will replace Supply Chain supplies used from the cart, replace the Supply Chain expiration label, then transport the cart with the completed Code 3 yellow sheet to the Pharmacy;
4. A pharmacist will process the used tray, replacing used medications and will document the expiration dates of medications within the tray. A "Crash Cart Replacement List" form is completed, attached to the yellow code sheet and

placed in the Pharmacy Billing Coordinator's work bin. A photocopy of the replacement form is kept with Emergency Cart Log

5. The pharmacist will then verify that the drawer locking mechanism is functional and document the results on the Crash Cart Replacement List. Plant Operations will be notified if service is needed.
6. The medication tray will then be secured with a green plastic lock and the cart secured with a green plastic lock.
7. The cart will be labeled with an expiration date that represents the nearest expiration date of all medications in the tray.
8. Supply Chain will then be notified that the cart is ready. The person from Supply and the pharmacist will initial the Supply Chain Log Book recording the number of the new lock. The person from Supply Chain will then take the supplied cart back to Supply Chain.
9. A Pharmacist will check the logbook each month for drugs about to expire. When necessary Pharmacy will exchange the drugs that are about to expire. The replacement drugs should have at least a six-month expiration date if possible. Supply Chain will also review their log and replace supplies as they expire.
10. The carts in the different drug storage areas will be verified as locked and in date at the time of the monthly unit inspection.
11. All departments which maintain crash carts.
    a. Test defibrillators daily. (Refer to Admin Policy I-51.0)
    b. Verify the integrity of the lock daily.
    c. Maintain a record of the checks on the crash cart and defibrillator battery check log (date, results, by whom). Form #750 will be utilized. (Except in CCU, they have their own form due to multiple defibrillators in patient rooms).
12. In addition to the above, Critical Care Units will test Code 3 buttons weekly and a record of the checks is maintained in the PBX Office. Only those defibrillators designated for transporting may be removed from their assigned units. These transporting defibrillators are located in ED, ICU, CCU, and Open Heart. No suction machines are to be removed from their assigned units.

C.

"*<u>CODE G</u>*" addresses a potential medical situation occurring on the Hospital grounds.

1. <u>House Supervisor</u> – A Registered Nurse who serves as a clinical and professional role model, functioning as staffing coordinator for the Nursing Division during assigned shift. Serves as a consultant within the Hospital in the areas of nursing practice, administration and interpretation of policies, medical-legal issues, legal nursing responsibility as indicated by the Florida Nurse Practice Act or other pertinent regulation. Serves as a liaison and acts in the behalf of Hospital Administration and Nursing to assure communication of significant situations and to facilitate the provision of patient care.

In a Code G situation, the following procedure will be implemented:

1. Upon discovery of a person who appears to need medical attention, any Hospital employee will call the Hospital Operator by dialing 4111 (the Hospital's universal emergency phone number) and stating "Code G" and location. The Switchboard

Operator will open page "Code G" and location and will initiate beeper notification, including location, to the House Supervisor, Security and House Orderlies.

2. An Emergency Department Registered Nurse and Emergency Department Security personnel will go to the stated location where the nurse will initiate an appropriate triage to determine if an emergency medical condition exists.
3. House Supervisor will report to the scene.
4. The House Supervisor has the authority to initiate measures he or she deems appropriate to provide for the patient's apparent needs, which can include:
    a. Transporting the involved party(s) to the Emergency Department; and/or
    b. Exercise other appropriate alternatives, including calling 911 for response when it is determined this in the patient's best interest.

D.

See complete policy and procedures to be followed for a potential medical situation occurring on Hospital grounds.

 "***CODE BROWN***" addresses actions to be taken in the event of a tornado watch and/or warning.

General Safety Guidelines for Patient Care Areas

1. All personnel shall review their severe thunderstorm/tornado disaster plans and evacuation plan.
2. Close shades or drapes over all windows.
3. Remove all items not essential for patient care and place in drawers or lockers.
4. Secure non-patient care areas by removing items and placing them in wardrobe.
5. Advise and reassure patients that the above precautions are taken whenever there is a severe weather warning.
6. Lower beds to lowest position. Ensure patients have their nurse call button
7. Provide all patients with a blanket or bedspread, which may be used to protect them if necessary.
8. Move all charts, unit dose medication carts, emergency carts, etc. to an inside room.
9. Prepare equipment that may be needed to move patients in the event of a Tornado Warning, including:
    - Blankets
    - Wheelchairs
    - Linens
    - Patient care equipment

General Safety Guidelines for Patient Care Areas

1. Close all blinds, shades and drapes.
2. Remove loose objects from desk and counter tops and windowsills.
3. Secure all wheeled carts in your work area.

If a tornado warning is issued, the following procedures shall be instituted:

1. Personnel will begin to move patients to corridors.
2. Place blankets, linens and mattresses on the floor of safe areas to provide a place for

patients to lie down.
3. Move patient care equipment needed to care for patients to corridors.
4. Maintain appropriate space in corridors for personnel to move safely among Patients.
5. Close all doors.
6. Personnel shall assist patients in lying flat or crouching down with head covered with blankets. All personnel shall also assume the prone or crouching positions and keep their heads covered.

When the "All Clear" is given, the following procedures shall be instituted:

1. All personnel shall assist in restoring their work areas to normal operations.
2. Personnel shall assess their department for damage or safety hazards and report them to the area supervisor.
3. After patient rooms have been evaluated for damage and safety hazards, patients may be moved back to their rooms. If a patient's room is uninhabitable, alternate accommodations shall be made.

Emergency Response

1. All casualties will be treated according to the Disaster Plan.
2. In the event the Hospital is damaged, a partial or total evacuation shall be
E. determined by the Chief Executive Officer. Refer to the Hospital Evacuation Plan.
3. Each department shall maintain the on-call system in the event relief staff are unable to report to their designated shifts.

"*CODE M*" is the process for obtaining manpower in an emergency necessitating the physical management of a patient. 1. Code M is initiated by dialing **4111**.
2. In an extreme emergency, the Sheriff's Department is to be contacted for assistance. The Administrative Assistant/Nursing, or his/her designee, must initiate the call to the Sheriff's Department after conferring with the nurse in charge.
3. Law Enforcement personnel responding to the Code must have weapons secured.

Team Members

1. RN in charge of unit.
2. Switchboard Operator
3. Unit Staff
4. Designated Personnel (Plant Operations Personnel; Administrative Assistant/ /Nursing; Security; Environmental Service personnel; House Orderly; Transporters)

Procedure

1. Check physician's order, if appropriate, to aid in planning intervention.
2. Determine the appropriate intervention to be used in view of patient's behavior.
   a. Call physician if any question regarding involuntary status or if restraint order or medication order is needed.
   b. In extreme emergency, ask the Administrative Assistant/Nursing, or his/her designee, to contact the Sheriff's Department for assistance, and assume

command of the situation after conferring with the nurse in charge.
3. Have staff member call Switchboard Operator to page "Code M".
4. Give specific directions to staff in order to carry out intervention. <u>Team effort is essential</u>.
    a. Assign staff member to obtain needed medication.
    b. If seclusion room is to be used, have personnel prepare room.

Responsibilities of Switchboard Operator. Page "Code M" three (3) times, identifying the Pavilion and/or nursing unit only.

Responsibilities of Staff

1. Staff Member on Stand-By:

    a. Stand at entry location to allow responding staff to enter area.
    b. Remind personnel to remove articles such as glasses, watches, name tags, pens, etc.
    c. Have Law Enforcement personnel secure weapons.
    d. Hold excess staff on a stand-by basis not allowing excess staff, other patients, or visitors to congest the area.

2. Staff Responding to Code M: Follow directions of the nurse on standby.
3. Staff Member with Patient:

    a. Tell patient what is being done and why.
        *   Remember that the patient is aware of what you are saying and doing and will remember it.
        *   Use brief explanations.
        *   Do not lie to patient or try to bargain with him/her. Do not promise things you cannot do.
        *   Approach the patient speaking in a low, firm, calm tone of voice.
    b. Attempt to verbally assist the patient in regaining control.
    c. If patient does not respond positively to verbal measures, attempt to physically restrain the patient in the safest possible manner.
    d. Explain to staff what is to be done and each responsibility, i.e., how patient will be transported and who will give medicine.
    e. Check pockets and remove all articles. May need to undress patient and redress patient in hospital gown. Remove shoes, belts, jewelry, glasses, cigarettes and any other articles that might be dangerous.
    f. After placing in seclusion room, follow policy for seclusion room.
        (Pavilion/Rehab only)
    g. If restraints are used, follow policy for restraints.
    h. Document appropriate notes on" Code M" Record (Pavilion only) or in Meditech.
        <u>Important points to include are:</u>
        *   Events preceding Code M.;
        *   Patient's behavior;
        *   The rationale and authorization for use of seclusion room and/or restraints;

- Document all articles removed for the patient and disposition of each article;
- Any medications given;
- Persons participating in the patient's management.

   i. Continue observation of patient with follow-up documentation as indicated.

   j. Follow-up with Involuntary Procedure if this has not been done (Pavilion Only)

F.

> **STAFF ALERT:** VIOLENCE IS A RESPONSE TO A SITUATION IN WHICH A PATIENT FEELS HELPLESS IN VIEW OF A PERCEIVED THREAT. APPROACHING THE SITUATION PROFESSIONALLY CAN PREVENT THE PATIENT FROM FEELING MORE NEED TO DEFEND HIMSELF/HERSELF AND STRIKE BACK.

"Code Pink" indicates that infant abduction is suspected, has been attempted or has occurred.

In a Code Pink, the following procedure will be implemented:

1. Upon discovery of the suspected/attempted or actual abduction, the Hospital employee discovering the event will call the Hospital Operator by dialing 4111 (the Hospital's universal emergency phone number) and stating, "Code Pink", the location and exit utilized, if on the Family BirthPlace. The Switchboard Operator will open page, "Code Pink" and location and will initiate beeper notification, including location and exit utilized (if on Family BirthPlace Unit), to the House Supervisor, Family BirthPlace Department Director, Director of Plant Operations, Director of Environmental Services, and all three (3) Security guards. The Hospital Operator will then contact the Medical Center Clinic Operator, the Administrator On-Call, and the Marketing Director to alert them of the situation.

2. The House Supervisor, Family BirthPlace Department Director, Director of Plant Operations, Director of Environmental Services, and the Inside Security Guard will report to the scene of the incident. At least the Inside Security Guard will utilize the stairwell nearest the exit location as stated on the "Code Pink" announcement.

3. The first of the following people to report to the scene will serve as a Code Pink Coordinator, until such time as all three (3) are present: House Supervisor, Family BirthPlace Department Director, and Administrator On-Call. The Code Pink Coordinator's primary purpose is to ensure that the procedures, as outlined in the Infant Protection Plan (found in V-18.0 of the Administrative Policy Manual) are followed.

G.

"*Code Red*" addresses the actions to be taken in the event of fire.

1. Do not shout "fire," state "Code Red"
2. Think "R-A-C-E"

   "R" Rescue people from the vicinity. Close the door.

   "A" Alarm activation.

    a. Pull the fire alarm box located:
    b. Pick up the phone and dial 4111.
    c. State Code Red and your location.

"C" Contain the fire
    a. Close all doors.
    b. Check to see that the fire exits are clear.

"E" Extinguish if you can do so safely, go to the area with fire extinguisher and attempt to extinguish.

3. Evacuate. Employees may evacuate patients to the next set of fire doors.
4. Assist Fire Safety team and fire department, if building evacuation is necessary.
5. Department oxygen shut off valves are to be turned off by Plant Operations personnel at the direction of the unit charge nurse.
6. If outside of assigned area, report back to your area.
    a. Close all doors and windows.
    b. Station one person at the telephone.
    c. Be prepared to lend assistance.
    d. Check for signs of smoke or fire in your area.
    e. Do not call the operator until 'code red clear" is announced.
    f. Reassure patients and visitors.

(For complete policy/procedure see MOX Library Safety Management Program #13 Fire

H. Safety Plan)

"Code Green/Situation 100" addresses the mass casualty/internal ore external disasters Level 1, II, III.

    Condition I - (Up to 15 casualties)
    Condition II - (Estimated 16-30 casualties)
    Condition III - (Estimated 31 or more casualties)

1. See (and know where) your departmental disaster plan for departmental specific instructions.
2. Know where to report for a Code Green.
3. Do not use the telephone unless absolutely necessary.
4. Visitors and families of disaster victims or hospital personnel will be directed to and will remain in the hospital cafeteria.

(For complete policy/procedure see Mox Library Safety Management Program – Disaster

I. Plan and/or Nursing Services Policy Section 1 Nursing Services - # 7 Disaster Plan).

" **Code Silver**" addresses the process to provide assistance to staff members, patients, and/or visitors, who are confronted by an individual brandishing or claiming to possess a weapon, or one who has taken hostages within the healthcare facility or within its property.

When **4111** is called to initiate the **Code Silver,** an overhead announcement will be made announcing the location. The Operator will call 911 and notify selected individuals.

Staff members should not attempt to intervene or negotiate, but seek shelter, behind locked doors if possible and remain out of public view until the **"Code Silver, All Clear"** is announced.

Security will report to the Code Silver area and lock down the doors to the area and post a Security Guard at the entrance. Security will keep everyone out of the area and will relinquish primary responsibility for security to the first representative of Law Enforcement to arrive on the scene. Law Enforcement will have security authority at this time.

J. For complete policy refer to Safety Management Plan – Emergency Management Plan.

SILENT CODES: These codes are not announced by overhead page. Key personnel will be notified by the Hospital Operator and/or the Administrator On Call.
"Code Yellow" addresses the process for securing and locking down an area within the facility or the entire facility

1. A lockdown is called by the hospital administrative person on call in response to a violent situation within or an external threat of violence or terrorism. The hospital was in lockdown with limited access during recent hurricanes.

(For complete policy/procedure see Mox Library – Adm. Policy – VII Facility Management – VII-25 Facility Lockdown)

 "Code Orange" addresses the process to respond to hazmat/Bioterrorism alert either internal or external.

1. Situation 100 level 1, 2 or 3. This is a Hazmat or Bioterrorism alert
   a. Call 4111 if aware of a spill
   b. The operator will notify the administrator
   c. Evacuate the area, if possible, contain the spill

(For complete policy/procedure see Mox Library – Administrative Policy – V-Safety – V-20 HazMat Emergency Response)

C. "Code Black" addresses the process for a bomb threat.

1. When warning of a bomb threat is received by telephone, you should:
   a. Prolong the conversation as much as possible
   b. Take notes such as:
      1) Background noises
      2) Voice characteristics of the caller
      3) Ask where & what time the bomb will explode
      4) Caller's familiarity with the facility
      5) Ask what the bomb looks like
      6) Exact words of the caller

2. Immediately have someone call PBX-4111 "Code Black" no overhead page.

3. If time permits, notify the <u>first available</u> of the following Hospital Officials ONLY:
   a. President/CEO
   b. Chief Operating Officer
   c. Administrator on-call(evenings & weekends)
   d. Plant Operations Director
   e. The House Supervisor

4. <u>Be Alert for:</u>
   a. Unusual packages (tubular or cylindrical)
   b. A package that does not "belong"
   c. Unnecessary articles/clutter should be removed
   d. People who act in an unusual manner or people who enter the hospital with packages and leave empty-handed

5. <u>If a bomb is found</u>:
   a. DO <u>NOT</u> TOUCH IT
   b. CLEAR THE AREA
   c. If applicable, close the room door
   d. Notify Plant Operations Director and when assistance arrives, offer cooperation

(For complete policy/procedure see Mox Library – Safety Management Program – Bomb Threat.)

FORMS: Crash Cart Form #700, Code Documentation Form #93, CSR Log, Pharmacy Log

REFERENCES: BCLS standards from American Heart Association, ACLS from American Heart Association.

Summary Table of Codes:

Code	3/Blue	Red	G	Brown	M	Pink	Green	Silver
Definition	Cardiac/ Respiratory Arrest	Fire	Person down on grounds	Severe Weather	Manpower needed	Infant abduction	Mass Casualty/Disaster (Level 1-2-3	Hostage violence
Procedure	Call 4111	Call 4111	Call 4111	Call 4111	Call 4111	Call 4111	Call 4111	Call 4111
	Initiate CPR	RACE PASS	Stay with victim until help arrives	Move patients at charge nurses direction	Assist as directed	Observe exits and stairwells	See your departments disaster plan	

SILENT CODES

CODE YELLOW	CODE ORANGE	CODE BLACK
CALL 4111	CALL 4111	CALL 4111
LOCKDOWN	HAZMAT/ BIOTERRORISM	Bomb Threat

Fire Safety Review

Know the fire alarm location closest to your area of work.

If you see a fire hazard, report it at once to your supervisor or correct it immediately.

Know how to use fire extinguishers.

All doors opening onto the corridor must not be propped open. Door latches must close tightly.

All exits are marked with lighted exit signs.

Portable heating devices are prohibited in the hospital.

All corridors must be clear of obstructions.

IN CASE OF FIRE

REMEMBER TO R.A.C.E.

R – RESCUE

A – ALARM

C – CONTAIN

E – EXTINGUISH

WHEN USING A FIRE EXTINGUISHER,

REMEMBER TO P.A.S.S.

P – PULL

A – AIM

S – SQUEEZE

S – SWEEP

OSHA HAZARD COMMUNICATION
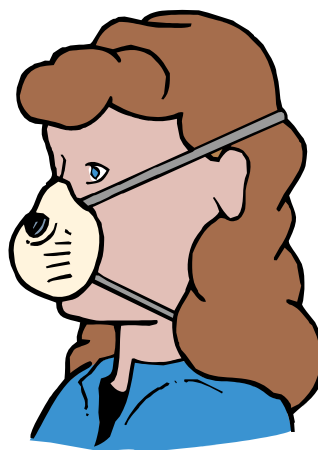
Hazardous Chemicals/Hazard Communication

Hazardous chemicals are located throughout various areas here at WFH. As a healthcare employee it is important that you understand your responsibilities when working with hazardous chemicals. By doing so, you are protecting our patients, yourself, and your fellow employees from potential injury.

OSHA's (Occupational Safety and Health Administration) **Hazard Communication Program,** often referred to as **"Right to Know",** is designed to protect employees from exposure to hazardous chemicals in the workplace. There are four main components to Hazard Communication programs:

Employee Education

Container Labeling

Material Safety Data Sheets (MSDS)

Written Program

(See the Safety Manual-Hazardous Material Management Program in the Disaster Plan, Filing Number 46-50)

The standard requires that as an employee you know:

- The term "Material Safety Data Sheet" (MSDS) and where the MSDS are located in your department. MSDS contain pertinent information on hazardous substances such as the chemical name, hazardous ingredients, precautions for safe use, required equipment for use, first aid procedures, and spill and disposal procedures. Where applicable, MSDS are located in every department.

- The types of personal protective equipment (PPE-gloves, aprons, safety eyewear, etc.) required to be worn when working with each chemical.

- What to do in the event of a chemical spill.

- The meaning of any labels placed on any chemical containers that you use in your work. Labels should include the name of the chemical, the name and address of the manufacturer, and the physical and health hazards of the chemical.

Hazardous Material Management Program

POLICY STATEMENT: West Florida Hospital is committed to the health and safety of its employees, patients, visitors, and to the protection of the environment of the surrounding community. The intent of this program is to comply with federal, state, and local regulations and accreditation requirements by establishing and maintaining a place of employment that manages recognized hazards that could harm persons or property. The Hazardous Material Management Program is the responsibility of the Environmental Management Safety Subcommittee and operates within the framework of our existing Safety, Quality Improvement, and Risk Management activities to protect our employees, patients and visitors and to minimize the exposure of the hospital to liability claims.

In order to conduct our business of providing healthcare services, we must use certain materials that require specific precautions to be taken to protect our employee's health. Therefore, it is the policy of West Florida Hospital to communicate any hazards associated with handling hazardous materials to employees involved in those operations.

Employees Responsibilities:
1. Obey the established safety rules.
2. Use personal protective equipment as required.
3. Dispose of hazardous materials safely; for example: dead batteries are sent to Plant Ops.
4. Inform your supervisor of:
    a. Any symptoms of overexposure that may possibly be related to hazardous chemicals.
    b. Missing labels on containers.
    c. Malfunctioning safety equipment.
    d. Any damaged containers or spills.

Employee Training:
Employees receive training regarding hazardous materials:
1. Upon employment - during Hospital Orientation - O.M.E.N.
2. During clinical orientation - unit specific training for hazardous chemicals in the workplace.
3. Annually - A.M.E.N.
4. Any time a new chemical is brought into the workplace- example, changing cleaning products that have a different chemical base.
5. Annually - for hazardous chemicals in the workplace - unit specific training - safety KARDEX.

Material Safety Data Sheets (MSDS)
1. Each unit must have MSDSs available for each hazardous chemical in the workplace. Employees must have access to the MSDSs 24 hours a day. Ask where they are.
2. If any MSDSs are missing, copies can be obtained from Supply Chain.

MSDSs will tell you:
* The name of the chemical
* Health hazards, results of overexposure (acute and chronic)
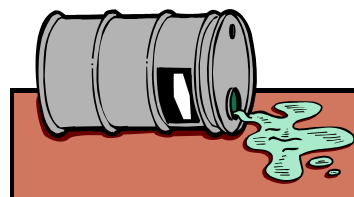
* Safe handling precautions
* Spill/leak procedures
* Proper disposal of the chemical

Spill: the loss of control of a substance that may cause harm to staff, patients, or others who come into contact with the substance. All departments will notify Plant Ops (Ext. 4888) of hazardous spills (chemical). The Laboratory will only notify Plant Ops for mercury spills, as the lab will handle its own chemical, biomedical and biohazardous spills. Special spill kits are used by Plant Ops for mercury and chemotherapy drugs. West Florida Hospital has a mercury free environment.

Procedure Overview	
Biomedical (Blood/Body Fluids) Spills	**Hazardous (Chemical/Mercury) Spills**
1. Apply gloves, gowns, etc. as needed.	1. Evacuate the immediate area. Co-workers, patients, and visitors shall be informed and removed from affected area.
2. Cover spill with paper towels and spray with disinfectant.	2. Notify your immediate supervisor of the spill.
3. Using dry paper towels, wipe up spill.	3. Call Plant Ops
4. Clean area again with detergent-disinfectant.	4. Obtain the Material Safety Data Sheet to give to Plant Ops
5. Contact Environmental Services if additional cleaning is needed	5. Plant Ops will follow the precautions on the MSDS for spills, protective equipment and disposal.
6. Place all biomedical waste into a red bag	6. Complete an Occurrence Report.
	7. Staff will work with Plant Ops as necessary

Now - It's your turn...

* Find your unit/department's location of MSDSs
* You will need to know:
    -**WHERE** the MSDSs are
    -**WHAT** the hazardous chemical is
    -**WHAT** the safety precautions are for each chemical
    -**WHAT** to do in case of a spill/leak
    -**WHAT** signs and symptoms of overexposure are
    -**WHAT** immediate first aid should be rendered in the event of an acute exposure
    -**HOW** to clean up a spill

Radiation Safety

As a healthcare worker, you know that radiation is an important tool for detecting and treating diseases. Radiation is one of the most highly regulated occupational fields. You are protected by many safeguards.

One way for hospital personnel to keep their radiation exposure to a minimum is to respect radioactive signs posted on doors and containers. The signs are always yellow and purple in color and may look like this:
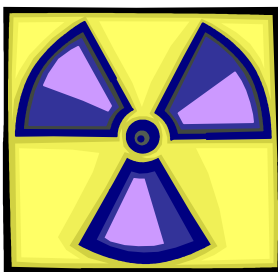
The signs may have different messages, such as **CAUTION RADIATION AREA** or **CAUTION HIGH RADIATION AREA** or **CAUTION RADIOACTIVE MATERIALS.** Entering areas identified as Radiation Areas requires special permission. Hospital personnel should check with authorized personnel before entering these posted areas.

Patients treated with therapeutic radioactive materials are to be confined to their rooms except for special medical or nursing procedures approved by the Radiation Safety Officer (RSO). No nurse, visitor or attendant who is pregnant should be permitted in the room of a patient who has received therapeutic amounts of radioactive material until the patient no longer presents a radiation hazard.

Healthcare personnel caring for/working around these patients/radioactive materials and/or their environments should have additional training. Please contact your supervisor or the Radiation Safety Officer (RSO) or his Deputy for any questions you may have regarding radiation, radiation safety, or radioactive materials. Information regarding radiation safety may be found in the **Safety Manual** under Radiation Safety in the Safety Plan and "Handling the Radiation Accident Victim" in appendix 1 of the Disaster Plan. The function of the Radiation Safety Sub-Committee and a list of the committee members are also found in the **Safety Manual** under Sub-Committee Functions and Responsibilities.

Important telephone numbers:

Radiation Safety Officer (RSO) - Gerald Lowery, MD	474-8264
Deputy Safety Officer	ext. 4722
Diagnostic Imaging	ext. 5343
Nuclear Medicine	ext. 5333
Nuclear Cardiology	ext. 4722
Radiation Oncology (Cancer Institute)	474-8264

MSDS Number: I8840 * * * * * *Effective Date: 08/27/04* * * * * * *Supercedes: 05/07/03*

ISOPROPYL ALCOHOL (90 - 100%)

1. Product Identification

Synonyms: 2-Propanol; sec-propyl alcohol; isopropanol; sec-propanol; dimethylcarbinol
CAS No.: 67-63-0
Molecular Weight: 60.10
Chemical Formula: (CH3)2 CHOH
Product Codes:
J.T. Baker: 0562, 5082, 9037, 9080, U298
Mallinckrodt: 0562, 3027, 3031, 3032, 3035, 3037, 3043, 4359, 6569, H604, H982, V555, V566, V681

2. Composition/Information on Ingredients

```
Ingredient CAS No Percent Hazardous
-------------------------------------- ----------- ----------- --------
Isopropyl Alcohol 67-63-0 90 - 100% Yes
Water 7732-18-5 0 - 10% No
```

3. Hazards Identification

Emergency Overview

WARNING! FLAMMABLE LIQUID AND VAPOR. HARMFUL IF SWALLOWED OR INHALED. CAUSES IRRITATION TO EYES AND RESPIRATORY TRACT. AFFECTS CENTRAL NERVOUS SYSTEM. MAY BE HARMFUL IF ABSORBED THROUGH SKIN. MAY CAUSE IRRITATION TO SKIN.
SAF-T-DATA(tm) Ratings (Provided here for your convenience)

Health Rating: 2 - Moderate
Flammability Rating: 3 - Severe (Flammable)
Reactivity Rating: 2 - Moderate
Contact Rating: 3 - Severe
Lab Protective Equip: GOGGLES & SHIELD; LAB COAT & APRON; VENT HOOD; PROPER GLOVES; CLASS B EXTINGUISHER
Storage Color Code: Red (Flammable)

Potential Health Effects

Inhalation:
Inhalation of vapors irritates the respiratory tract. Exposure to high concentrations has a narcotic effect, producing symptoms of dizziness, drowsiness, headache, staggering, unconsciousness and possibly death.
Ingestion:
Can cause drowsiness, unconsciousness, and death. Gastrointestinal pain, cramps, nausea, vomiting, and diarrhea may also result. The single lethal dose for a human adult = about 250 mls (8 ounces).
Skin Contact:

May cause irritation with redness and pain. May be absorbed through the skin with possible systemic effects.

Eye Contact:
Vapors cause eye irritation. Splashes cause severe irritation, possible corneal burns and eye damage.

Chronic Exposure:
Chronic exposure may cause skin effects.

Aggravation of Pre-existing Conditions:
Persons with pre-existing skin disorders or impaired liver, kidney, or pulmonary function may be more susceptible to the effects of this agent.

4. First Aid Measures

Inhalation:
Remove to fresh air. If not breathing, give artificial respiration. If breathing is difficult, give oxygen. Get medical attention.

Ingestion:
Give large amounts of water to drink. Never give anything by mouth to an unconscious person. Get medical attention.

Skin Contact:
Immediately flush skin with plenty of water for at least 15 minutes. Call a physician if irritation develops.

Eye Contact:
Immediately flush eyes with plenty of water for at least 15 minutes, lifting lower and upper eyelids occasionally. Get medical attention immediately.

5. Fire Fighting Measures

Fire:
Flash point: 12C (54F) CC
Autoignition temperature: 399C (750F)
Flammable limits in air % by volume:
lel: 2.0; uel: 12.7
Listed fire data is for Pure Isopropyl Alcohol.

Explosion:
Above flash point, vapor-air mixtures are explosive within flammable limits noted above. Contact with strong oxidizers may cause fire or explosion. Vapors can flow along surfaces to distant ignition source and flash back. Sensitive to static discharge.

Fire Extinguishing Media:
Water spray, dry chemical, alcohol foam, or carbon dioxide. Water spray may be used to keep fire exposed containers cool, dilute spills to nonflammable mixtures, protect personnel attempting to stop leak and disperse vapors.

Special Information:
In the event of a fire, wear full protective clothing and NIOSH-approved self-contained breathing apparatus with full facepiece operated in the pressure demand or other positive pressure mode.

6. Accidental Release Measures

Ventilate area of leak or spill. Remove all sources of ignition. Wear appropriate personal

protective equipment as specified in Section 8. Isolate hazard area. Keep unnecessary and unprotected personnel from entering. Contain and recover liquid when possible. Use nonsparking tools and equipment. Collect liquid in an appropriate container or absorb with an inert material (e. g., vermiculite, dry sand, earth), and place in a chemical waste container. Do not use combustible materials, such as saw dust. Do not flush to sewer! If a leak or spill has not ignited, use water spray to disperse the vapors, to protect personnel attempting to stop leak, and to flush spills away from exposures.
J. T. Baker SOLUSORB® solvent adsorbent is recommended for spills of this product.

7. Handling and Storage

Protect against physical damage. Store in a cool, dry well-ventilated location, away from any area where the fire hazard may be acute. Outside or detached storage is preferred. Separate from incompatibles. Containers should be bonded and grounded for transfers to avoid static sparks. Storage and use areas should be No Smoking areas. Use non-sparking type tools and equipment, including explosion proof ventilation. Containers of this material may be hazardous when empty since they retain product residues (vapors, liquid); observe all warnings and precautions listed for the product. Small quantities of peroxides can form on prolonged storage. Exposure to light and/or air significantly increases the rate of peroxide formation. If evaporated to a residue, the mixture of peroxides and isopropanol may explode when exposed to heat or shock.

8. Exposure Controls/Personal Protection

Airborne Exposure Limits:
For Isopropyl Alcohol (2-Propanol):
-OSHA Permissible Exposure Limit (PEL):
400 ppm (TWA)
-ACGIH Threshold Limit Value (TLV):
200 ppm (TWA), 400 ppm (STEL), A4 - not classifiable as a human carcinogen.
Ventilation System:
A system of local and/or general exhaust is recommended to keep employee exposures below the Airborne Exposure Limits. Local exhaust ventilation is generally preferred because it can control the emissions of the contaminant at its source, preventing dispersion of it into the general work area. Please refer to the ACGIH document, *Industrial Ventilation, A Manual of Recommended Practices*, most recent edition, for details.
Personal Respirators (NIOSH Approved):
If the exposure limit is exceeded, a full facepiece respirator with organic vapor cartridge may be worn up to 50 times the exposure limit or the maximum use concentration specified by the appropriate regulatory agency or respirator supplier, whichever is lowest. For emergencies or instances where the exposure levels are not known, use a full-facepiece positive-pressure, air-supplied respirator. WARNING: Air purifying respirators do not protect workers in oxygen-deficient atmospheres.
Skin Protection:
Wear impervious protective clothing, including boots, gloves, lab coat, apron or coveralls, as appropriate, to prevent skin contact. Neoprene and nitrile rubber are recommended materials.

Eye Protection:

Use chemical safety goggles and/or a full face shield where splashing is possible. Maintain eye wash fountain and quick-drench facilities in work area.

9. Physical and Chemical Properties

Appearance:
Clear, colorless liquid.
Odor:
Rubbing alcohol.
Solubility:
Miscible in water.
Specific Gravity:
0.79 @ 20C/4C
pH:
No information found.
% Volatiles by volume @ 21C (70F):
100
Boiling Point:
82C (180F)
Melting Point:
-89C (-128F)
Vapor Density (Air=1):
2.1
Vapor Pressure (mm Hg):
44 @ 25C (77F)
Evaporation Rate (BuAc=1):
2.83

10. Stability and Reactivity

Stability:
Stable under ordinary conditions of use and storage. Heat and sunlight can contribute to instability.
Hazardous Decomposition Products:
Carbon dioxide and carbon monoxide may form when heated to decomposition.
Hazardous Polymerization:
Will not occur.
Incompatibilities:
Heat, flame, strong oxidizers, acetaldehyde, acids, chlorine, ethylene oxide, hydrogenpalladium combination, hydrogen peroxide-sulfuric acid combination, potassium tertbutoxide, hypochlorous acid, isocyanates, nitroform, phosgene, aluminum, oleum and perchloric acid.
Conditions to Avoid:
Heat, flames, ignition sources and incompatibles.

11. Toxicological Information

Oral rat LD50: 5045 mg/kg; skin rabbit LD50: 12.8 gm/kg; inhalation rat LC50: 16,000 ppm/8-hour; investigated as a tumorigen, mutagen, reproductive effector.
```
--------\Cancer Lists\--------------------------------------------------
---NTP Carcinogen---
```

```
Ingredient Known Anticipated IARC Category
---------------------------------- ----- ---------- ------------
Isopropyl Alcohol (67-63-0) No No 3
Water (7732-18-5) No No None
```

12. Ecological Information

Environmental Fate:
When released into the soil, this material is expected to quickly evaporate. When released into the soil, this material may leach into groundwater. When released into the soil, this material may biodegrade to a moderate extent. When released to water, this material is expected to quickly evaporate. When released into the water, this material is expected to have a half-life between 1 and 10 days. When released into water, this material may biodegrade to a moderate extent. This material is not expected to significantly bioaccumulate. When released into the air, this material is expected to be readily degraded by reaction with photochemically produced hydroxyl radicals. When released into the air, this material is expected to have a half-life between 1 and 10 days. When released into the air, this material may be removed from the atmosphere to a moderate extent by wet deposition.

Environmental Toxicity:
The LC50/96-hour values for fish are over 100 mg/l. This material is not expected to be toxic to aquatic life.

13. Disposal Considerations

Whatever cannot be saved for recovery or recycling should be handled as hazardous waste and sent to a RCRA approved incinerator or disposed in a RCRA approved waste facility. Processing, use or contamination of this product may change the waste management options. State and local disposal regulations may differ from federal disposal regulations. Dispose of container and unused contents in accordance with federal, state and local requirements.

14. Transport Information

Domestic (Land, D.O.T.)

Proper Shipping Name: ISOPROPANOL
Hazard Class: 3
UN/NA: UN1219
Packing Group: II
Information reported for product/size: 200L
International (Water, I.M.O.)

Proper Shipping Name: ISOPROPANOL
Hazard Class: 3
UN/NA: UN1219
Packing Group: II
Information reported for product/size: 200L

15. Regulatory Information

```
--------\Chemical Inventory Status - Part 1\-------------------------------
```

```
Ingredient TSCA EC Japan Australia
------------------------------------------------ ---- --- ----- ---------
Isopropyl Alcohol (67-63-0) Yes Yes Yes Yes
Water (7732-18-5) Yes Yes Yes Yes
--------\Chemical Inventory Status - Part 2\-------------------------------
--Canada--
Ingredient Korea DSL NDSL Phil.
------------------------------------------------ ----- --- ---- -----
Isopropyl Alcohol (67-63-0) Yes Yes No Yes
Water (7732-18-5) Yes Yes No Yes
--------\Federal, State & International Regulations - Part 1\---------------
-SARA 302- ------SARA 313------
Ingredient RQ TPQ List Chemical Catg.
----------------------------------------- --- ----- ---- -------------
Isopropyl Alcohol (67-63-0) No No Yes No
Water (7732-18-5) No No No No
--------\Federal, State & International Regulations - Part 2\---------------
-RCRA- -TSCAIngredient
CERCLA 261.33 8(d)
----------------------------------------- ------ ------ ------
Isopropyl Alcohol (67-63-0) No No No
Water (7732-18-5) No No No
Chemical Weapons Convention: No TSCA 12(b): No CDTA: Yes
SARA 311/312: Acute: Yes Chronic: Yes Fire: Yes Pressure: No
Reactivity: No (Mixture / Liquid)
```

Australian Hazchem Code: 2[S]2

Poison Schedule: None allocated.

WHMIS:

This MSDS has been prepared according to the hazard criteria of the Controlled Products Regulations (CPR) and the MSDS contains all of the information required by the CPR.

16. Other Information

NFPA Ratings: Health: **1** Flammability: **3** Reactivity: **0**

Label Hazard Warning:

WARNING! FLAMMABLE LIQUID AND VAPOR. HARMFUL IF SWALLOWED OR INHALED. CAUSES IRRITATION TO EYES AND RESPIRATORY TRACT. AFFECTS CENTRAL NERVOUS SYSTEM. MAY BE HARMFUL IF ABSORBED THROUGH SKIN. MAY CAUSE IRRITATION TO SKIN.

Label Precautions:

Keep away from heat, sparks and flame.

Keep container closed.

Use only with adequate ventilation.

Wash thoroughly after handling.

Avoid breathing vapor or mist.

Avoid contact with eyes, skin and clothing.

Label First Aid:

If swallowed, give large amounts of water to drink. Never give anything by mouth to an unconscious person. If inhaled, remove to fresh air. If not breathing, give artificial respiration. If breathing is difficult, give oxygen. In case of contact, immediately flush eyes or skin with plenty of water for at least 15 minutes. Remove contaminated clothing and shoes. Wash clothing before reuse. In all cases, get medical attention.

Product Use:

Laboratory Reagent.

Revision Information:
MSDS Section(s) changed since last revision of document include: 16.
Disclaimer:
****
****

Mallinckrodt Baker, Inc. provides the information contained herein in good faith but makes no representation as to its comprehensiveness or accuracy. This document is intended only as a guide to the appropriate precautionary handling of the material by a properly trained person using this product. Individuals receiving the information must exercise their independent judgment in determining its appropriateness for a particular purpose. MALLINCKRODT BAKER, INC. MAKES NO REPRESENTATIONS OR WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION ANY WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE WITH RESPECT TO THE INFORMATION SET FORTH HEREIN OR THE PRODUCT TO WHICH THE INFORMATION REFERS. ACCORDINGLY, MALLINCKRODT BAKER, INC. WILL NOT BE RESPONSIBLE FOR DAMAGES RESULTING FROM USE OF OR RELIANCE UPON THIS INFORMATION.
****
****

Prepared by: Environmental Health & Safety
Phone Number: (314) 654-1600 (U.S.A.)

INFECTION CONTROL

The Infection Control department serves several purposes within the hospital. We are a resource when you have questions about anything related to infections, isolation, or other related topics. We also collect data about infections that occur in the hospital. If you have any questions, please feel free to call the department. This section will educate you about…

BLOODBORNE PATHOGEN/EXPOSURE CONTROL PLAN

TUBERCULOSIS (TB) CONTROL PLAN

ISOLATION PRECAUTIONS

If you have any questions, please ask.

You can reach the Infection Control department at
Ext. 3215 or beeper # 406-0306

Hand Hygiene

Hand Hygiene is especially important in the hospital because some patients are very weak and can easily develop infections. Germs are invisible to the naked eye and can be found almost anywhere. In October 2002, the Center for Disease Control (CDC) updated the hand hygiene guidelines. These guidelines are part of The Joint Commission National Patient Safety Goals.

Handwashing: The single, most important technique to prevent spread of infections!

- Lather hands with soap and water.
    Antimicrobial soap for general handwashing.
- Rub your hands together vigorously for at least 10 - 15 seconds.
- Rinse hands under running water in a downward position
- Dry hands using a clean, dry paper towel and discard towel.
- Use another clean, dry paper towel to turn off the faucet. Make sure you wash under rings and fingernails.

Alcohol hand gel is available in all patient care areas, visitor waiting rooms and the cafeteria. It is 99% effective against germs. It is used between patient contacts or after touching contaminated articles (linen, equipment) if hands are not visibly soiled. **This product is not to replace handwashing. Alcohol hand gel is not to be used in C-diffcile contact isolation rooms. Wash hands with antimicrobial soap and water at sink.**

Artificial nails to include gels, overlays, acrylic, and shellac are **NOT** to be worn in patient care areas, and should be removed prior to reporting to duty. Nails are to be kept clean and trimmed to ¼" long with no chipped polish. Limiting the amount of jewelry and keeping fingernails short will make handwashing more effective.

Hospital approved lotion is the only lotion to be used at **all** times. Other types of lotions have emollients that break down the barrier of gloves.

Glove Removal

While gloves DO NOT replace handwashing, they can help protect you from germs. It is important to remember that your hands should always be washed **after gloves are removed**.

To prevent contamination of your hands while removing gloves follow the following steps:
1. Peel one glove off from top to bottom and hold the glove in the gloved hand.
2. With the ungloved hand, peel the second glove off from the wrist, being careful to avoid touching the outside of the glove.
3. Dispose of the gloves in the proper trash container promptly.
4. Wash your hands.

Exposure Control Plan

What is the Exposure Control Plan?
OSHA requires all hospitals to develop an Exposure Control Plan to educate the staff about bloodborne pathogens (diseases spread through blood). This policy is found in the Infection Control Manual (Section 3).

What are bloodborne pathogens?
Bloodborne pathogens are bacteria, viruses, and other microorganisms that cause infections and are spread by blood. Examples are:

> Human Immunodeficiency Virus (HIV)
> Hepatitis B
> Hepatitis C
> Syphilis
> Malaria

What Are <u>Your</u> Responsibilities?

> You should know the Infection Control Manual is in Meditech. (The Exposure Control Plan is in Section 3), the purpose of the Exposure Control Plan, follow the practices in the Plan, and report problems relating to the Exposure Control Plan to Infection Control.

What Are the Hospital's Responsibilities?

> We must maintain the Exposure Control Plan, provide PPE and Engineering Controls that are appropriate for your job, clean or dispose of PPE at no charge to the employee, offer Hepatitis B Vaccination, and provide post-exposure follow-up.

What is Your Exposure Category?

Category I: Any employee who has the potential to contact blood, body fluids, during their routine job duties. (Physician, Nurse, housekeeper, therapist, lab personnel)

Category II: Employees who do not have the potential to contact infectious materials during their routine job duties. (Health Unit Coordinators)

Category III: Employees that have no exposure to blood or body fluids. (secretary, schedulers)

A complete list of Category I job titles is found in the Infection Control Manual (Section 3.01).
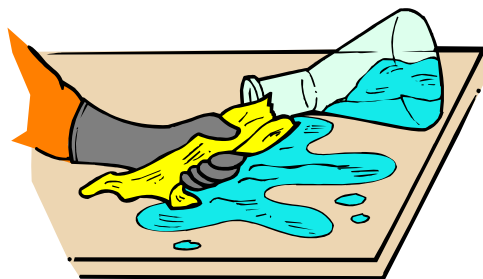
Biomedical & Biohazardous Waste

Biomedical Waste includes:

- Human blood, blood products, lymph fluid, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, and amniotic fluid.
- Anything caked with biomedical waste that may flake off during handling.
- Any non-absorbent item that is contaminated with biomedical waste.
- Absorbent materials soaked to capacity with biomedical waste.
- Non-liquid human tissues and body parts.

Disposal of Biomedical waste:

- Sharps (needles, scalpels, etc.) should be placed in designated sharps containers. Sharps containers must be replaced when they are 2/3rd full.
- Linen contaminated with blood/body fluids should be placed in yellow linen bags.
- All other Contaminated waste should be placed in a **red** Biomedical waste container.

Linen

ALL linen will be bagged in a yellow linen bag at the place of use. The linen bags **must** be closed and placed in the linen chute or designated container. Linen should not be placed in pillowcases or red bags. Linen must not be left unbagged.

Biomedical (Blood, Body Fluid) Spills

Lab will respond to all of their own spills.
Nursing floors will contain biomedical spills and call Environment Services for clean up.

1. Apply gloves, gowns, etc. as needed.
2. Cover spill with paper towels and spray with disinfectant.
3. Using dry paper towels, wipe up spill.
4. Clean area again with approved hospital detergent-disinfectant.

Cleaners

A hospital approved disinfectant that will kill most bacteria, viruses, and fungi will be used as a general cleaner disinfectant.

What if you are exposed?

If an employee has an exposure to blood or body fluids they will be counseled and offered post exposure testing that includes HIV, HBV, HCV, and alt..

If you get exposed to blood, body fluids, etc.
1. Wash the area with soap and water. (Flush the eyes with water)
2. Notify your supervisor.
3. Fill out an Occurrence Screen in Meditech. Must be done within the shift the incident occurred.
4. Call Employee Health immediately. If Employee Health is closed, page the House

Supervisor. It is important to get testing done on the source patient ASAP to determine treatment, if indicated, for the employee.

5. Complete drug screen in 3rd floor Lab.

If you get exposed to a patient with an infectious disease (TB and Meningitis), contact Employee Health.

Standard Precautions

Standard Precautions are used for all patients all the time. Standard Precautions means that PPE should be worn to protect you from all body substances. PPE should be chosen based on the task or procedure being performed and potential for contact. Standard precautions should be used when there is potential contact with blood, body fluids, secretions, or excretions (excluding sweat).

Personal Protective Equipment (PPE):

Gloves: We provide several types of gloves for employee use. Gloves should be worn to protect your hands if there is a chance that your hands may contact blood, body fluids, secretions, excretions, soiled linen, or dirty equipment. Exam gloves are single use and should not be reused.

Vinyl exam gloves are provided in each patient room and other patient care areas. Use vinyl gloves instead of latex to help reduce unnecessary exposure to latex.

Cleaning gloves are provided for all environmental personnel. These gloves should be used during cleaning. These gloves will protect you from bloodborne pathogens and cleaning chemicals. They should be wiped with disinfectant to remove contamination. Glove liners and other types of gloves are provided as needed.

Gowns: Gowns should be used whenever splashing may occur. Gowns will prevent fluids from coming into contact with your skin or clothing.

Masks: Masks are used to protect the nose and mouth from fluids. We provide several types of masks. Some masks have plastic eye shields that also protect the eyes.

Goggles/face shields: Goggles and plastic face shields provide the most effective way to protect your eyes from splashes.

Bag-Mask device is available on top of the crash cart as the barrier device in CPR.

Engineering Controls: The hospital provides tools to help reduce unnecessary exposures. Examples are sharp containers, needleless IV systems, blunt tip needles and self-sheathing needles.

Hepatitis B Vaccine: The Hepatitis B vaccine (HBV) is provided to all category 1 and 2 employees.
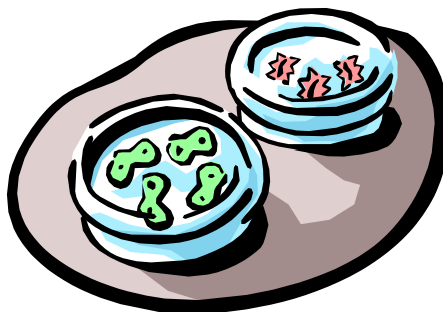
Isolation Precautions

Airborne Precautions are used for TB, Avian Flu, Measles and early eruptions of Herpes zoster. These precautions protect you from infections that can travel significant distances through the air or are extremely contagious.

N**-95 HEPA Respirators or Powered Air Purifying respirators (PAPR)** must be worn for TB patients. These patients must be in a negative-pressure room (218, 414, 416, 418, 449, 549, ICU 14, 15, 16, ER 11, 12 & PACU). All employees must be fit tested and receive training before a respirator can be used.

Droplet Precautions are used for diseases transmitted by droplets that can be generated by the patient during coughing, sneezing, talking or the performance of aerosolizing procedures. For example: SARS, meningitis, influenza and MRSA in sputum. Wear a regular surgical mask for close patient contact.

- Note: If performing an aerosolizing procedure or an influenza patient, a N95 mask must be worn. Aerosolizing procedures to include: Respiratory treatments, suctioning and intubation.

Contact Precautions are used for infections that are spread through direct (person-to-person) or indirect (person-to-environment) contact. You should always wear gloves and wash your hands with antimicrobial soap before and after caring for these patients. Patients with certain types of bacterial wound infections, gastrointestinal infections, and Herpes Zoster eruptions are dried and not draining will fall into this type of isolation. Gowns **MUST** be worn if there is close contact with the patient or bed linen. Alcohol hand gel **MUST NOT** be used when a patient is on isolation for clostridium difficle.

Implementation:
Signs will be posted on the patient's door stating the type of isolation and required PPE: Airborne (Pink), Droplet (Orange) and Contact (Yellow). PPE should be stocked for each patient. If you have any questions, call Infection Control or the House Supervisor. Strict Personal Protective Equipment usage is necessary when entering patient room as stated on isolation sign. A **DO NOT USE** sign for alcohol hand gel must be placed over the alcohol hand gel in rooms with C-difficle patients.

Patient Transport: When patients are transported, they should have the isolation precautions maintained. **Patients** on airborne or droplet precautions **should** be transported **wearing** a surgical mask. Patients on contact precautions must be transported on a stretcher or wheelchair covered with a clean sheet or other physical barrier. Healthcare workers should not wear personal protective equipment (PPE) to transport a patient. Using appropriate barriers on the patient is sufficient to protect the healthcare worker. The receiving department should be informed before the patient is transported and isolation precautions must be maintained until the patient returns to his/her room. Prior to transporting isolation patients, make sure the orange isolation sticker is placed on the front of the patient chart.

Isolation Policies are available in the Infection Control Manual in the Meditech Library. These policies list the conditions and the type of isolation required.

HIV and AIDS

What causes AIDS?
The Human Immunodeficiency Virus (HIV) attacks the immune system resulting in an inability to fight infections.

What is the difference between HIV infection and AIDS?
People who are infected with HIV may not have any signs or symptoms, but they are able to transmit the infection to others. People with AIDS have been diagnosed as infected with HIV and they either have a decreased CD4+ count or an opportunistic infection. Many people who may be infectious have not been tested for HIV; therefore ALL patients should be treated as if they are infected.

How can you become infected with HIV?
HIV is transmitted by sexual contact, through sharing needles, and through blood transfusions. A mother can also give HIV to an unborn child before birth or through breastfeeding. Health care workers can get infected through injuries by needles, scalpels, and other commonly used equipment.

How can you prevent HIV infection?
Prevention methods include reducing the risk of infection. Elimination of risky sexual activity and needle sharing, along with screening of blood products is essential for reducing infection rates. Pregnant women should be tested so treatment can be started, aimed at reducing the risk of infecting the unborn child. In the hospital environment, prevention of HIV infection can be achieved by routine use of Standard Precautions, PPE and sharps safety and disposal.

Confidential testing is available to identify infected individuals and teach them about risk reduction. Florida law requires every person that receives an HIV test to have pre-test and post-test counseling about HIV/AIDS. The Assistant Head Nurse is available to perform HIV pre-test counseling on patients prior to ordering the HIV test. (Infection Control/House Supervisor is available as a back-up counselor if the assistant nurse manager cannot perform counseling.) If you have any questions, call Infection Control.

Tuberculosis

How do I identify someone with TB?
A person who has Active TB usually has some (3 or more) of the following symptoms:

- Cough that lasts for more than three weeks

- Fever and chills

- Coughing up blood in the sputum

- Night sweats

- Weight loss and loss of appetite

- Fatigue and weakness

A person who has been exposed to TB may not get sick, but they will have a positive skin test or positive TB Quantiferon Gold.   Anyone who has a positive skin test or positive TB Quantiferon Gold test should contact a doctor if these symptoms appear.

How is TB spread?
TB is spread through the air. When a person who has TB coughs, talks, or sneezes, tiny drops of bacteria can be put in the air. If someone else breathes these in, the bacteria can spread to their lungs. They may cause TB or they can "hide" and cause TB later.

How can I protect myself from TB?
1. By knowing the symptoms of TB: If you know the symptoms of TB, you can help identify patients earlier and begin using the respirators and isolation.
2. Respirators: We provide special respirators for you to wear when you must be near a patient with TB. If you work in an area with TB patients, you will be fit tested annually for a respirator.
   - You should never wear someone else's respirator.
   - Students are not assigned to TB patients due to the medical evaluation and fit testing requirements.
   - You can get new respirators on the unit or in Supply Chain. A fit check is required every time you use a respirator for protection.
3. Isolation: Patients with known or suspected TB are placed on **AIRBORNE PRECAUTIONS.** They are placed in special rooms that have negative airflow with respect to the hallway. The doors to these rooms must be kept closed. There are 12 of these rooms in the hospital. They are 218, 414, 416, 418, 449, 549, ICU 14, 15, 16, ER 11, 12 & PACU. Respirators are required to be worn by all people entering the room. Patients with TB should be transported wearing a regular surgical mask.
4. Visitors are provided with respirators along with instruction on how to don the respirator. Respirators are supplied to visitor to offer them the same level of protection of the staff.

What if I get exposed to a TB patient?
If you are exposed to a patient with TB, contact Employee Health. If your skin test or Quantiferon Gold test becomes positive, you will have a chest x-ray and be evaluated for preventative medication.

MRSA & VRE

Methicillin is a very strong antibiotic that is used to treat infections.
Resistant means that the antibiotic will not kill the bacteria.
Staphylococcus
Aureus is a type of bacteria carried by many people.

Vancomycin is a very strong antibiotic that is used to treat infections.
Resistant means that the antibiotic will not kill the bacteria.
Enterococcus is a type of bacteria found in the GI tract.

Why are we concerned about MRSA?

MRSA is a bacterium that is resistant to Methicillin. This means that it may cause an infection that is very difficult to treat. Most patients with MRSA infection are treated with Vancomycin, a very strong antibiotic. MRSA likes to cause infections and can become very serious.

Why are we concerned about VRE?

VRE is a bacterium that is resistant to Vancomycin. This means that it may be very difficult to treat if it is causing an infection. VRE does not usually like to cause infections, but when it does there may not be an effective treatment for the patient.

Who gets MRSA & VRE?

Surgical patients: Open wounds create an ideal environment for MRSA. Surgical patients also may be weak following surgery and may have a harder time fighting infections.
Invasive Devices: Gastric/endotracheal tubes, catheters, and surgical drains are also good environments for MRSA to grow. Special care should be taken with these patients to avoid contaminating the devices.
Intensive Care/Severely Ill: Patients who are in very poor health are more likely to get infections. These patients have lowered immune defenses and may have difficulty fighting infections.
Age: Newborns and the elderly are more likely to get infections.
Treatment with antibiotics: Patients who have been treated with a lot of antibiotics may have infections that are more difficult to treat. Antibiotics can reduce the number of helpful or weaker bacteria that may make infections harder to fight.

What if the patient is "Colonized"?

Colonized patients have the bacteria, but the bacteria are not making them sick. They can still spread the bacteria to others and may develop infections at a later time.
Infected patients have the bacteria and it is making them sick. They may have a surgical wound infection, urinary tract infection, or an infection at some other site. Infected patients are capable of spreading the bacteria to others.

How can we prevent MRSA & VRE in our patients?
<u>Handwashing is the most important thing we can do.</u>

Patients with MRSA and VRE are placed in CONTACT Isolation. Gloves and/or gowns should be worn while in the room to prevent spreading the bacteria to other areas. Any equipment used in the room or on the patient should be cleaned and disinfected before using on another patient.

MRSA

West Florida Hospital has increased the awareness on preventing the spread of MRSA to our patients, visitors and staff. This campaign includes performing nasal swabs on patients who are having cardiac surgery, spinal surgery, knee or hip surgery, patients who have a history of MRSA, dialysis patients, patients who have an open wound, and patients who are transferred from another hospital or nursing home facility. As part of this campaign, WFH places patients who have a positive MRSA nasal swab on contact isolation. Patients who have a positive MRSA sputum culture must be placed in Droplet Isolation.

RISK MANAGEMENT

Areas of Potential Liability for Healthcare Workers

Increasingly, healthcare workers are being named as defendants in medical malpractice claims. As in any negligence action, the plaintiff must show that the defendant breached a duty of care to the plaintiff and that this breach was the proximate cause of the plaintiff's injury. Following are the major areas of potential liability:

Following the Chain of Command: WFH has an established policy on "Chain of Command". The Chain of Command principle allows and requires a healthcare worker to notify his/her superiors whenever he/she believes that a patient's condition is not being adequately addressed. For example, if a nurse believes a physician is not responding appropriately to a patient's condition, the nurse must notify the next person in the chain of command. In this case the chain of command could include the nurse's direct superior, i.e. unit nurse manager, then house supervisor, the Chief Nursing Officer, Administrator on call, or the Medical Director. Failure to follow the chain of command with resulting patient harm or injury is deemed as negligence.

Prevention of Injuries: Healthcare workers have a duty to prevent injuries to patients and provide a safe and secure environment. Examples of common injuries to patients which might be deemed as a result of a healthcare worker's negligence include injuries resulting from a) falls, b) misuse of restraints, c) misuse of equipment, d) misuse of medications, e) decubiti and other skin injuries, f) use of improper methods of transferring and transporting patients, etc.

Monitoring of Patient's Condition: This is one of the most frequent causes of healthcare workers being named in malpractice claims. Nurses and others are responsible for monitoring their patients. Failure to do so may constitute negligence. Along with the duty to monitor their patient's healthcare workers also have the duty to promptly report and significant changes in a patient's condition to the patient's physician and to thoroughly document in the patient's record the fact that he/she did notify the patient's physician and the content of information communicated to the physician.

Communicating Information to Physicians: Healthcare workers have a duty to communicate relevant data about a patient to the treating physician regardless of the time of day, instructions from the physician that he/she is not to be called, possible physician backlash for calling him/her, how busy the healthcare worker's day is, etc. Furthermore, a healthcare worker has the responsibility to follow the chain of command if the treating physician does not respond to a call or page in a timely manner.

Following Physician's Orders: Healthcare workers may be liable for failing to properly follow a physician's orders for a patient. If a healthcare worker is unclear about the nature or intent of a physician's order, he/she should seek clarification prior to carrying out the order. Also, it is prudent for healthcare workers to double-check the chart before carrying out an order to make sure that the order has not been discontinued or changed.

Prevention of Medical Errors

The Joint Commission Standard LD.5.2 requires healthcare facilities to select at least one high-risk process for proactive risk assessment each year. This choosing of a specific process is to be based, at least in part, on information provided by the Joint Commission concerning the most frequently occurring types of sentinel events.

Sentinel Event Definition

- Event that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's, client's or resident's illness or underlying condition.

- Or the event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Suicide of a patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
  - Abduction of any patient receiving care, treatment, and services.
  - Infant abduction or discharge to the wrong family;
  - Rape;
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - Surgery on the wrong patient or body part.
  - Unintended retention of a foreign object in a patient after surgery or other procedure.

A suspected sentinel event needs to be entered into the Risk Management Module and a telephone call made to the Risk Management Department.

Occurrence Reporting System

SCOPE: Policy encompasses West Florida Hospital including Rehabilitation Institute and Pavilion and applies to all employees, visitors, physicians and patients.

PURPOSE: To ensure a system for Occurrence Reporting which results in a systematic procedure to (1) detect, report, collate, analyze and summarize incidents; (2) develop appropriate measures to minimize the risk of injuries and adverse incidents to patients; (3) identify areas of actual/potential hospital liability and exposure and (4) assist in the management of claims for the facility.

POLICY: All Medical Staff members, West Florida Hospital employees and other agents have an affirmative duty (legal obligation) to report incidents and occurrences to the Risk Manager using the Online Occurrence Reporting System in the Risk Management Module of Meditech. **FAILURE TO REPORT INCIDENTS MAY RESULT IN SUSPENSION OR TERMINATION OF EMPLOYMENT.**

1. **WORK-RELATED INJURIES OR ILLNESS:**
    A. **All employee** work injuries or exposures/illness must be reported via the Employee Report Section of the Risk Management Module. Employees are responsible for reporting work-related medical conditions to Employee Health prior to seeking non-emergency medical assistance, evaluation or treatment by a physician. All follow-up visits for work-related injuries should be coordinating with Employee Health. (Refer to Administrative Policies: Workers' Compensation V-10.0 through V-10.4 and Transitional Duty V-11.0 through V-11.4).
    B. **Volunteers** are not covered under Workers' Compensation. If a volunteer is injured, treatment given directly by the Hospital is charged to Policy/Discount (Account #500206). Other treatments should be covered by the Volunteer's health insurance plan. In unusual circumstances, the Hospital may pay expenses up to $1,000 charged to Volunteer Services (Account #525317). Reporting should be made on an Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module.
    C. **Private duty personnel, independent contractors and students** are not Hospital employees. Therefore, the Hospital is not responsible for injuries received by them while performing their duties. While the Hospital provides initial exposure protocol testing by Employee Health (when necessary), these individuals are responsible for payment of all other healthcare services received at our Hospital. Reporting will be made on an Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module.

2. **NON-PATIENT INJURIES OR OCCURRENCES:**
    A. **VISITOR –** If a visitor sustains an injury while on the premises of West Florida Hospital, it is the option of that visitor to decide whether or not to be seen in the Emergency Department or seek health care following the accident or injury. Visitor incidents are reported on the Non-Patient Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module. Whether or not the visitor is charged for the emergency visit is a decision of the Risk Manager and Hospital

Administration and no guarantee of payment should NOT be offered initially without express approval of one of these individuals.

B. **FACILITY OCCURRENCES:** Occurrences or incidents unrelated to a specific patient or entity as identified above area also to be reported on the Non-Patient Occurrence Report utilizing the Online Occurrence Reporting System in the Risk Management Module of the Hospital's Meditech program. Since the Occurrence System is a name driven system, all occurrences will be entered under the pseudonym of "Joe Facility".

3. **PATIENT INJURIES OR OCCURRENCES:**
   A. Any incident related to a patient or his/her care should be reported on a Patient Occurrence Screen utilizing the Online Occurrence Reporting System in the Risk Management Module of the Hospital's Meditech System.

PROCEDURE:

OCCURRENCE SCREENS:
1. An "Occurrence Screen" is a factual written statement regarding a particular incident, which details the time and location of the occurrence as well as all persons directly involved and their titles. The "Occurrence Screen" also includes the nature of the event and a description of any injuries. The screen should also contain a listing of witnesses to the event.

   A. **Responsibility for completion:**
   The employee having knowledge of the facts or the employee who observed the incident performs preparation of the report. All Occurrence Screens should be completed totally and fields are made "mandatory" in such a way as to prohibit the person reporting the incident from filing the report until all required fields have been completed. (See attached educational packets for end-users, employees and managers). Healthcare providers should document those facts concerning the occurrence, which are pertinent to the patient's care in the medical record. (i.e. actual medication given should be recorded in MAR as well as any treatment rendered, results of monitoring, or patient changes per appropriate nursing documentation protocols).

   B. **Documentation in the Medical Record:**
   The "Occurrence Screen" is a confidential report of an incident or adverse event and is **not a part of the medical record.** Also, no notation that an Occurrence Screen was completed is to be made in the body of the medical record.

   C. **Confidentiality of the "Occurrence Screen":**
   The Online Occurrence Screen Reporting system in the Risk Management Module is designed in such a way that the ability to "print" an occurrence screen is limited only to the Risk Manager and/or his/her designee. **OCCURRENCE SCREENS ARE NEVER TO BE COPIED.**
   The "Occurrence Screen" is a totally confidential work tool to be used for hospital reporting purposes only and is therefore a statutorily protected document. **NEVER** discuss or release any information contained in the report unless authorized by the Risk Manager or CEO. Anyone requesting such information should immediately be referred to the Risk Manager.

   D. **Timeliness of Reporting:**

The Risk Manager must receive the "Occurrence Screen" within (3) calendar days. The Online Occurrence Reporting System facilitates this process by making all reports accessible to the Risk Manager as soon as the individual completing the online "Occurrence Screen" has filed their portion of the report.

Occurrence Screens may be filed "after-the-fact" as soon as an occurrence is identified. If an incident is of significant gravity, it should be reported immediately to the Risk Manager or to the Administrative Assistant/Nursing after business hours. The Nursing Supervisor may contact the Risk Manager or Risk Manager Designee. Phone numbers and/or beeper numbers for these individuals are available through the operator as well as the In-house telephone directory.

E. **Access to Occurrence Screens:**
Only authorized end-users have access to complete an Occurrence Screen. The manager of that department may review occurrence screens for a specific department only. Managers do not have access to reports completed anywhere except on their unit. Once an Occurrence Screen has been completed and sealed by the Risk Manager, access to that Occurrence Screen is prohibited by any other individual.

Visitors, patients, families and healthcare surrogates are not required to sign or verify the report, and it should not be reviewed by them, nor, should they be given a copy. If they wish to provide input, they may do so by providing a written copy of their comments, observations to Risk Manager.

F. **Serious Incident Evaluation:**
In the instance of an actual or potentially serious injury, all investigations will be coordinated and directed by the Risk Manager.

3. **RISK MANAGEMENT/QUALITY IMPROVEMENT ACTIONS:**
The Risk Manager or designee will review all occurrence screens and request appropriate follow-up actions when necessary. If an occurrence report raises an actual or potential quality of care issue, the information will be referred to Quality Improvement for peer review processing and recommendations in accordance with the applicable Quality Improvement policies and procedures.

4. **CATEGORIES WHICH ARE CONSIDERED HOSPITAL OCCURRENCES:**
The following is a general list of categories that are considered Hospital Occurrences:
A. Events that are not consistent with routine patient care when compared to accepted standards.
B. Violation of established policies and procedures that involve patient care.
C. An accident to an employee, visitor or patient with or without injury.
D. An event with injury that is considered a potential claim or lawsuit.
E. Mishaps due to faulty or defective supplies or equipment or unsafe environmental conditions.
F. Unexpected adverse results of professional care and treatment, which necessitates additional hospitalization or a significant change in patient treatment regimens.
G. Patient, visitor or employee property loss or damage.

5. **EXAMPLES OF SPECIFIC OCCURRENCES WHICH REQUIRE COMPLETION OF AN OCCURRENCE SCREEN:**
Some specific occurrences that require the completion of an Occurrence Screen may include, but are not limited to:

A. Patient Falls – all types.
B. Treatment or Testing Related Incidents – including procedure variations by nursing, medical or technical staff, equipment problems leading to actual or potential patient injury, nosocomial decubiti formation, severe IV infiltrations or any IV-related phlebitis, or any complications or adverse patient occurrences as a result of treatment or testing.
C. Other Incidents – including patient-induced injuries, safety or security problems, pressure (decubitus) ulcers, which develop after admission, missing or damaged patient property, patient/family complaints, which include threat of legal action and visitor, related incidents.
D. Medication Variations – errors in medication administration, delays greater than one hour from scheduled dosing time, missed or extra doses, unresolved narcotic discrepancies or violations of narcotics sign off policies and procedures.
E. Equipment malfunction or breakdown.

6. **EQUIPMENT FAILURE/PRODUCT DEFECT:**
If equipment, instruments or products used for patient care are involved in an incident, accident, injury or near injury:
A. Equipment should be removed immediately, tagged with information about the problem, and Supply Chain notified.
B. Notify Risk Management and complete an Occurrence Screen, noting the serial number or identification number on the equipment.
C. Depending on the severity of the incident, material evidence may be sequestered by the Risk Manager.

Protocol for sequestering equipment:
A. When a patient is injured and a piece of equipment is involved, the equipment should simply be unplugged. No dials or settings should be touch. All packaging and accessories should also be collected and sent to Risk Management along with the equipment.
B. The equipment or product should not be returned to the manufacturer without the approval of the Risk Manager or CEO.

7. **TRANSFERS FROM OUTSIDE AGENCIES:**
If a patient is transferred from another agency and any of the following are noted, an Occurrence Screen must be completed and forwarded to the Risk Management Department:
A. Patient received in an unstable condition.
B. Patient in active labor.
C. Receiving physician not contacted by the transferring physician and an agreement made to accept the patient.
D. Transfer mode and/or personnel utilized for transport were not qualified to meet needs of the patient during transfer process;
E. Memorandum of Transfer form did not accompany the patient from referring facility and transferring hospital did not provide copies of appropriate medical records of the patient's examination and treatment at the transferring hospital.

DEFINITIONS:

ADVERSE OR UNTOWARD INCIDENT:
According to Florida Statute § 395.0197 (2001) and Florida Administrative Code 59A-10.002 (2001)(5), an adverse or untoward incident for reporting purposes is defined as an event over

which healthcare personnel could exercise control and:

(a) Is associated in whole or in part with medical intervention as described in below under the term medical intervention, rather than the condition for which such intervention occurred, and

(b) Is not consistent with or expected to be a consequence of such medical intervention; or

(c) Occurs as a result of medical intervention to which the patient has not given his informed consent; or

(d) Occurs as a result of any other action or lack thereof on the part of the facility or personnel of the facility; or

(e) Results in a surgical procedure being performed on the wrong patient; or

(f) Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedure; and

(g) Causes injury to a patient as defined below under injury.

An incident is also defined by West Florida Hospital as an event or occurrence, which is not consistent with the routine operation of the hospital, the routine care of a patient or the expected results of the care administered to a patient. This includes incidents or occurrences with or without injury involving patients, visitors or employees as well as an occurrence, which could evidence employee/physician negligence or incompetence.

<u>INJURY:</u>

An "injury" for the purposes of reporting to the Agency is any of the following outcomes when caused by an Adverse incident:

(a) Death; or

(a) Brain damage; or

(b) Spinal damage; or

(c) Permanent disfigurement; or

(d) Fracture or dislocation of bones or joints; or

(e) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition; or

(f) Any condition requiring surgical intervention to correct or control; or

(g) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care; or

(h) Any condition that extends the patient's length of stay; or

(i) Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility.

MEDICAL INTERVENTION:

Medical Intervention means actions of any health care facility or personnel of the facility, in the provision of health care.

REFERENCES: Florida Statute §395.0197 Internal Risk Management Program

Patient Notification of Medical Errors

West Florida Hospital strives to promote an atmosphere of honesty and respect as pertains to keeping patient informed in all aspects of their care. There are times when medical errors occur in an institution. At times these errors can result in injury or harm to a patient. Should this occur, it is of utmost importance to assure that information is relayed by an appropriate individual, is done in the most appropriate setting and includes all of the information necessary for the patient/family to make informed decisions. To ensure consistency in this process we have established guidelines for providing information to patients and/or families/significant others when:

- A significant medical error occurs in the patient's care and results in harm, or
- Unanticipated outcomes have resulted from care, treatment and services that have been provided and the patient or family must be knowledgeable about these outcomes to participate in current and future decisions affecting their care.

The facility will notify patients and/or the patient's families when significant medical error occurs as soon as possible after the error is discovered, with the direction of the Chief Executive Officer (CEO) in consultation with the Chief of the Medical Staff.

The Chief Executive Officer (CEO), in consultation with the attending or covering physician, and the Chief of the Medical Staff, has the primary responsibility for initiating the procedures that 1) determines whether an event meets hospital-defined level of significance for notification, and 2) results in the patient and/or family being informed of the event.

The patient's attending or covering physician will have the primary responsibility for ensuring that the patient is informed. Other practitioners, such as the patient's primary care nurse, may be designated to perform notification. The Patient Care Team, made up of the nurse manager, clinical pharmacist, and case manager, will also be involved in notification and should be fully prepared to answer or readily obtain an answer to any questions the patient and/or family may have about the incident. So in addition to the patient's physician, the patient's nurse, a pharmacist, or a manager should be present to help answer questions. The patient and/or family should be notified in a private place. Ideally, they should receive prompt notification. Time should be provided for staff to respond to patient/family questions and concerns, if any should arise in the course of this discussion.

At a minimum, the patient and/or family should be informed about:

- The known nature of the error that occurred
- Any known possible repercussions the error may have on the patient's care and on short- and long-term health, and the proposed plan to respond to these changes should they occur.
- Point of contact for further questions and/or follow-up.
- Avenue of recourse
- Case Manager
- Risk Managers
- External agencies / list of names and address of professional review boards)
- VP Medical Affairs

After notification, a physician progress note will be made in the medical record and signed by the practitioner who notified the patient of the error as well as any other caregivers present for the discussion.   Also, an occurrence screen should be prepared and submitted.
If the patient's clinical condition or care may be negatively impacted by notification after the event, then this discussion should be held with the appropriate family members, if possible. Otherwise, the notification may be deferred until a more appropriate time. The reason for deferring more than 24 hours must be documented in the physician progress notes. If the error is reported or discovered after discharge or completion of services at facility, the patient and/or family should be notified as soon as information about the error and its impact on the patient's health has been determined, as well as any actions that need to be taken by the patient/family member. At that time, the attending physicians will dictate/write an addendum to medical record regarding notification of patient/family member.

If the incident is the subject of litigation (or potential litigation), legal counsel for the facility may be consulted with respect to the process of notifying the patient and the information to be disclosed, and the procedures may be altered as a result of counsel's advice in that particular case.

Patient Notification of Adverse Events

```
                    ┌──────────────────────┐
                    │    Event Occurs      │
                    └──────────────────────┘
                               │
                    ┌──────────────────────┐
                    │    Notify Risk       │
                    │    Manager           │
                    └──────────────────────┘
                               │
                          ◇ Hospital-defined
                            significant event        No        ┌──────────┐
                            that caused harm  ──────────────── │   End    │
                            – result of error? ◇               └──────────┘
                               │
                             Yes
                    ┌──────────────────────┐
                    │    Risk Manager      │
                    │    Notifies CEO      │
                    └──────────────────────┘
                               │
                          ◇ Decision made
                            to activate
                            protocol for           No          ┌──────────┐
                            patient       ──────────────────── │   End    │
                            notification? ◇                    └──────────┘
                               │
                             Yes
                    ┌──────────────────────┐
                    │   CEO consults with  │
                    │ Attending Physician  │
                    │   and Chief of Staff.│
                    └──────────────────────┘
                               │
                          ◇ Continue           No             ┌──────────┐
                            Protocol? ◇ ──────────────────────│   End    │
                               │                              └──────────┘
                             Yes
        ┌──────────────────────────────────────┐
        │ Meeting to review facts, designate   │
        │ roles/presenter, identify point of   │
        │ patient contact going forward.       │
        └──────────────────────────────────────┘
                               ○
                               ○
```

RISK/QUALITY **CLINICAL**

2

| Internal Quality Peer Review. | External Agency Reporting. | Potential Claim Report | Claims | Root Cause Analysis | Notify Regional Quality Department. | Patient meeting – use scripts; collects questions/concerns, point of contact for family, next steps |

Is it a reportable event?

No → End

Yes

Report completed to agency. Agency may do follow-up and ask for RCA.

RCA Reviewed

Meet with family within 48 hours to update and design/determine next steps.

Next Steps? No → End

Yes

Advance Directives, Living Wills, & DNR Policies

1. Upon admission to the hospital each patient shall be asked if they have an Advance Directive.
2. If the patient is incapacitated, the patient's next of kin or guardian will be asked if the patient has executed an Advance Directive and if so, they will be told to bring the Advance Directive to the hospital. This request should be documented in Meditech. (Advance Directive Intervention will be "completed.")
3. The following information will be copied and put in the medical record:
   - Designation of Healthcare Surrogate/Proxy, or
   - Living Will, or
   - Medical or Durable Power of Attorney

Living Wills, Advance Directives, Healthcare Surrogate Designations and Medical Durable Power of Attorney are valid, unless the patient states that they have been changed, amended, revoked at any time.

DNR – DO NOT RESUSCITATE
1. Signed by MD
2. Definition – during cardiac and/or respiratory arrest patient will not be resuscitated.

HEALTHCARE SURROGATE
1. Signed by patient and witnessed.
2. Definition – a legal document by which a person appoints another person (called agent, attorney-in-fact, or surrogate) to act on his/her behalf to make medical decisions for the patient if the patient should become temporarily or permanently unable to make these decisions.

LIVING WILL
1. Signed by patient
2. Definition – a witnessed document in writing or a witnessed oral statement voluntarily made by the person that expresses the person's instructions concerning life-prolonging procedures only when that person is terminally ill, in an End Stage condition, or in a persistent vegetative state. It is called a Living Will because it takes effect while the patient is still living.
3. Explanation - When the patient's condition is such that any other treatment is futile, the patient can decide to stop further medical care and accept only care that will make him more comfortable. A Living Will goes into effect only when the patient is too sick or injured to speak for himself and when doctors believe he will not survive without the use of machines or aggressive treatment. If there is a reasonable chance that the patient can be restored to health, the Living Will won't apply.

   A Living Will can be cancelled or changed at any time.

Ethics Committee (Bio-Ethics)

PURPOSE: The committee shall serve as an educational resource in the Hospital to encourage, facilitate and coordinate education in bio-ethics for members of the Hospital staff, professional and nonprofessional, and the community. This Hospital Administration Committee serves in an advisory capacity when consulted to assist physicians, other healthcare professionals and patients and their families in making bio-ethical decisions. The Committee may make recommendations on policies concerning bio-ethical issues to Administration.

CONFIDENTIALITY: All discussions and deliberations, which pertain to particular patient's circumstances, shall be treated as strictly confidential. All reports, documents, minutes, etc. will be maintained in accordance with hospital policy.

PROCEDURE TO INITIATE BIO-ETHIC CONSULTATION: The Bio-Ethics Committee recognizes the right of the patient or the patient's designated representative to participate in the consideration of ethical issues that arise in the care of the patient. The Committee will maintain consultation teams composed of members of the Committee. Response to consultation requests will be timely (within 24 hours or the next working day) between the initiation of the request and initial review.

Requests for bio-ethics consultation may be made by patient/families, patient-designated representatives, physicians, nursing staff, and ancillary staff.

CONSULTATION: The Team Leader will notify the team members to assist with the consultation. The Team may review the patient's medical record and hold discussions with the patient/family or patient's surrogate, the physician, and the requester, as needed.

The Team will work in an advisory capacity to assist in the resolution of the ethical concern. The team will provide educational material and discussion to caregivers and the patient or patient-designated representative to assist in an understanding of ethical issues surrounding the case. A summary note will be made in the physician progress notes upon completion of the consultation.

General Facts on Organ Donation and Transplantation

LifeQuest Organ Recovery Services, the federally designated organ procurement organization (OPO) for northern Florida is responsible for all organ donor referrals.

LifeQuest is based in Gainesville and has four satellite offices: Jacksonville, Tallahassee, Panama City and Pensacola.

The mission of LifeQuest is three-fold:
1. To offer families the option of donation
2. To recover organs for transplant
3. To educate the community on the importance of organ donation

The organ donation process involves several steps, including:
1. Making a referral: House Supervisor refers a potential organ donor to LifeQuest.
2. Obtaining consent: Only after a patient has been declared brain dead and the family has been notified of the death will we begin discussion about donation.
3. Placing the organs: After the family has given consent for donation, the procurement coordinator will consult the waiting lists to determine which potential transplant recipients will be offered the organs.
4. Recovering the organs: Once the transplant centers accept the offers of the various organs, an operation time will be arranged.

Patients awaiting organ transplants in the United States must be listed on the national waiting list, which is maintained by the United Network for Organ Sharing (UNOS).

Individuals can sign a donor card and carry it in their wallet or sign up to be an organ donor when they renew their driver license. Most importantly, individuals need to talk to their family about their decision to become a donor.

For more information on organ donation, please call (800) 535-GIVE.

PROCESS IMPROVEMENT

How Can One Person Improve Quality?

Every person is a key to quality improvement, and that includes you. The following sections list 10 ways you can make your mark in your organization's **quest for quality.**

Role 1: Do It Right the First Time

In your own work, learn the job and pay attention to the details so that you do the job right the first time. Know that your job is your self-portrait, and sign your autograph with quality. When a medical secretary forgets to enter a charge into a chart, when an orderly lifts a patient in a way that makes the patient uncomfortable, when a physician writes an illegible medication order, when an environmental services person has to return to a patient room to clean a shower that was neglected during regular rounds, when a customer complains, when a bill is mailed to a patient or insurance company without complete information – all of these situations require rework or the correction of mistakes. These in turn frustrate the customer, cost the organization money, and require more of an employee's time. That's why doing the job and the task right the first time is so important. Every error, oversight, or job left half-done is a quality problem. Because supervisors can't be looking over your shoulder all the time (and you wouldn't want them to even if they could), you need to take responsibility for the quality of your own work.

Role 2: Listen to Your Customers and Aim to Meet Their Expectations

Recognize how your customers define quality and strive to give them what they want. Show a customer-service orientation and strengthen your customer-service skills. An important aspect of quality is "meeting customer expectations". As health care providers, we can't take for granted that we know what our external customers (patients) and internal customers (co-workers) want unless we ask them, take seriously what they tell us, and then do all we can to meet or preferably even exceed their expectations. A clinically skilled nurse might think that excellent clinical care is what matters most in delivering quality. Although clinical care is certainly important, if the patient and family expect the nurse to demonstrate compassion and understanding too, this must accompany clinical excellence in order for these customers to be satisfied. To fulfill your role in quality, you need to listen to your customers. You can't reliably assume that you know what they want without asking and then taking action to meet their expectations.

Role 3: Treat Your Co-Workers and Other Departments as Customers

Help co-workers serve their customers by meeting their needs. When coworkers take care of each other, the organization works for everyone. Although service extended to patients and physicians is essential to your organization's mission, excellent service to these external customers only happens if staff – on the inside of the organization – work well together and support each other in the chain of events leading to excellent patient care. Nurses, for instance, have many internal customers, such as the people in departments such as the pharmacy, linen, dietary, environmental services, maintenance, radiology, labs, and many more. These departments also need to regard the nursing staff as their customers. Your department and everybody in it, needs to develop and sustain mutually supportive *partnerships* with your internal customers in order to make your organization work well for patients. Such

partnerships only happen when every individual treats co-workers as customers and does everything possible to reflect cooperation and teamwork across departmental lines.

Role 4: Confront Poor Quality When You See It

Starting today, don't walk past a problem, error, or example of shoddy service without comment or action. Take responsibility. How many times have you seen co-workers notice a frustrated patient or physician and either say, "Sorry, it's not my job," or pretend not to notice? Instead of letting poor quality happen, every person needs to step in and do what he or she can to make things right. Also, when you see another department or employee "guess" about a dosage on a medication order instead of checking, or deliver a tray they know to include the wrong food, or tolerate endless waits in their waiting area day after day, speak up, offer help. When you notice quality problems but say and do nothing, you're part of the problem. When you speak up or act, you're part of the solution.

Role 5: Stretch; Don't' Settle

Know that when you stop actively improving your work, quality doesn't stay the same; it slips. In your words and personal actions, show ever-higher standards for yourself and those you influence. Some people do just enough to get by on the job. But that "getting by" attitude threatens quality improvement. To make quality ever better, every individual needs to adopt that "good enough never is" attitude and strive for excellence in his or her own work. That means you need to push yourself to become more skillful and to stretch your own capabilities and contributions – to learn.

Role 6: Seize Opportunities to Get Involved

You can make a difference only if you assert yourself. Speak up, make suggestions, join quality teams, become part of the solution. You will probably have increasing opportunities to become involved in making quality improvements. Whether by participating in staff meetings, serving on quality teams, or making suggestions, there are undoubtedly ways you can constructively identify problems and recommend possible improvements, drawing on your firsthand experience with your customers, what customers need, and how things work in your specialty area. While getting involved does take time, people who seize opportunities to become involved find it extremely stimulating and revitalizing. It's a chance to break your job routines, get to know other people, see the "bigger picture" in your organization, and make your mark.

Role 7: Look for Solutions

Don't point the finger, blame, or gripe. *Act* to make things better. From your vantage point, you've undoubtedly seen problems and felt frustrations that seemed to go on day after day. Under those circumstances, it's easy to become cynical or feel hopeless about the possibilities for change. However, if you give up on change for the better and complain, blame others, or gripe about problems instead of joining in and helping with solutions, you make matters worse. Griping, finger pointing, and blaming drain the energy of the people trying to make things better. And if you truly want improvements in your organization, you need to give change a chance. In many organizations actively pursuing quality improvement for the first time, blaming and complaining have proved to be among the most debilitating obstacles to positive change. If
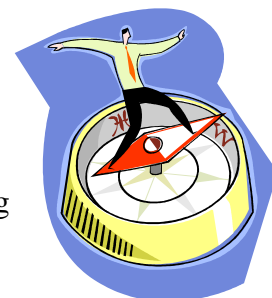
you're among the people who feel skeptical about the commitment or ability of your organization, administration, or supervisor to make things better because of they're past performance, try to suspend your disbelief and give them a chance. Better yet, offer your support and help so that you use your potential influence positively.

Role 8: Appreciate Quality When You See It

Reflections of quality are all around you. Stop, take notice, recognize, and congratulate the people and teams responsible for quality service and solutions. It's not unusual to take quality for granted and say something about it only when things go wrong. The problem is that it takes energy to keep quality high and, without recognition, people have trouble sustaining energy for quality work. Appreciation for contributions to quality is also important because it focuses attention on what's happening *right* and makes it more likely to happen right in the future. That's the power of reinforcement. Some employees think that their supervisors should be the main dispensers of pats on the back for positive performance, but why? Imagine what would happen if your co-workers quadrupled the appreciation they express to you for the good things you do for patients, for physicians, and for them. Compliment the phlebotomist who consistently finds the patient's vein on the first try; thank the telephone operator who persists until he or she finds that doctor you need to reach; comment about the speed at which the medical secretary is transmitting orders for tests; tell your co-workers how supported you feel when they step in to help you when the pressure builds. Make yourself a positive force that reinforces quality in others.
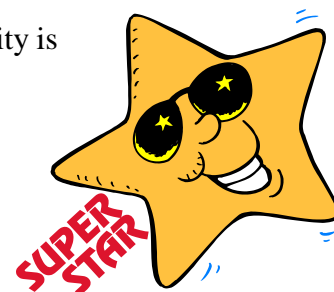
Role 9: Pursue Continuous Improvement in Yourself

Learn, read, and expand your skills so that you can be ever more effective in making quality happen. The quality organization is a "learning" organization. This means that the people in it study other people's effective approaches, learn from them, experiment with new methods, study the results, and make improvements. The organization *learns* and becomes more effective over time. How does that happen? Through the people. It's the people within the organization who have to open themselves to new ways of doing things and becoming experimental in their approach to their work. To improve your contributions to quality, you can take steps to strengthen your job skills through reading, attending educational programs and training sessions offered in your organization, asking questions, and learning from co-workers. If you're open to self-development, you can find ways to become more effective in your job and an ever more valuable contributor to your organization's quality track record.

Role 10: Become a Quality Advocate

Dare to go public with your commitment to quality. Talk it up. Express optimism. Be a positive and inspiring influence to improve quality. Because change – even change for the better – can be tiring, it takes commitment. If you're committed to quality improvement, then express your commitment by being willing to say, "It's about time" and "I'm glad this is happening here"

and "I'm going to believe it will work until it's proven otherwise." Imagine – if everyone waited to see everyone else commit himself or herself before joining in, nothing would happen. Be brave to step forward and say, "I'm in! How can I help?"

Being a Contributor to Quality - The 10 roles described in the preceding sections represent ways you can personally step forward and become a reflection of quality and a full-fledged contributor to quality improvement in your organization. The good news is that not only will your patients and your organization benefit, you'll no doubt be energized by your involvement and become invaluable to your organization.

The Joint Commission On-site Survey Process

In 2006, The Joint Commission has changed the method of site surveying that they will do for the triennial accreditation. Previously, the accreditation organization sent surveyors who looked very thoroughly at the implementation of set hospital standards. The process required weeks of preparation and many felt that the "ramp-up" required to get ready for the survey provided an unrealistic setting to see how patient care was actually being done. The new on-site survey process evaluates more reality and the old process evaluated more potential problems.

The new survey agenda will be looking at the organization through the eyes of a patient. The survey will include patient tracer activities, which means the surveyor will examine all aspects of a patient's experience traced through the organization from his admission to discharge. They look at continuity of care, how well the caregivers' work together, and the quality of patient safety to determine how the organization is performing. After doing several patient tracers, the surveyors will also do system tracers, which means they will examine a specific system which include, but are not limited to medication management and infection control. They will examine the entire medication management system/tracer and infection control system/tracer within the hospital focusing on how the processes within these systems work. The priority focus areas (PFA), those processes and systems that impact quality of care and safety of care in a healthcare organization are communication, staffing, information management, and credentialed practitioners at West Florida Hospital.

Staff will be asked to talk to the surveyors. They may be asked about a protocol or procedure and would answer questions about what they have done concerning the specific care of the patient being traced. They may also be asked what is your role to protect the safety of out patients? The site surveyor will then interpret the staff's answers in relation to the specific standard that is being evaluated. If the information given by the staff is not enough to help the surveyor understand WFH processes, further questions will be asked.

The Joint Commission also performs Disease-Specific Care surveys to provide certification to a hospital for one or more disease-specific care program. WFH has maintained the Disease Specific Care Certification for its Stroke Program.

Joint Commission: Hospital Accreditation Standard

Any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to the Joint Commission:

E-Mail:
complaint@jointcommission.org

Fax:
Office of Quality Monitoring
(630) 792-5636

Mail:
Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630-792-5000

No disciplinary action will be taken by the hospital if an employee reports concerns to The Joint Commission. All staff are encouraged to use the Chain of Command for immediate action to resolve concerns.

E. M. T. A. L. A.
Emergency Medical Treatment and Active Labor Act 42 U.S. C. Section 1395 and F.S. 395-1041

The E. M. T. A. L. A law states that a patient, including a born-alive infant or pregnant woman in labor, who presents to a hospital with dedicated emergency department requesting emergency treatment must have an appropriate Medical Screening Exam (MSE) by an ER physician, another physician or other Qualified Medical Personnel (QMP) without regard to the person's ability to pay. The qualified medical personnel are Physician Assistants, A.R.N.P.'s, Certified Nurse Midwives and qualified labor and delivery nurses in consultation with the attending OB physician.

At West Florida Hospital, the Emergency Department and the Family Birthplace labor and delivery unit are the designated sites for a Medical Screening Exam.

 The law requires that signage about E.M.T.A.L.A. must be present and visible in the designated sites and must be in English and Spanish.

FMECA

West Florida Hospital will also identify patient safety events and high-risk processes that may be selected for this annual risk assessment. The process that we use to analyze and proactively correct potential problems is called FMECA. Failure mode and effects and criticality analysis (FMECA) is a disciplined approach used to identify possible failures of a product or service and then determine the frequency and impact of the failure. Failure mode and effects and criticality analysis (FMECA) is also the tool used to recognize and evaluate the potential product or process failure and its causes associated with the designing and manufacturing of a product. FMECA was developed in the 1960's in the aerospace industry to enhance safety and to increase customer satisfaction.

There are 10 steps in the FMECA process. By moving through each of these steps, WFH can determine root causes of potential or real problems and develop methods to prevent these root causes from occurring in the future. The employee needs to be aware of the availability of this process and that the hospital management team desires to utilize this process to improve care and prevent problems.
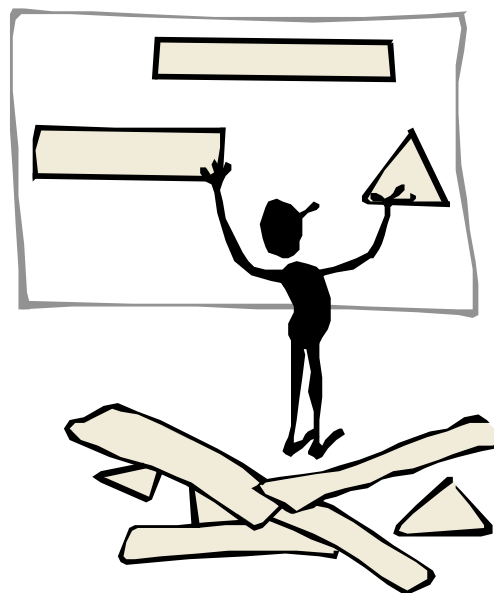
10 Steps of the FMECA Process:
1. Review the Process
2. Brainstorm potential failure modes
3. List potential effects of each failure mode
4. Assign a severity rating for each effect
5. Assign an occurrence rating for each failure mode
6. Assign a detection rating for each failure mode and/or effect
7. Calculate the risk priority number for each effect
8. Prioritize the failure modes for action
9. Take action to eliminate or reduce the high risk failure modes
10. Calculate the resulting RPN as the failure modes are reduced or eliminated

EMPLOYEE SAFETY

Employee Health and Safety

A. SAFETY

Employees must observe and practice the hospital's safety rules in every phase of work. These safety rules are explained to employees during initial orientations and on-going in-services and education programs such as the A.M.E.N. Employees are required to participate in the safety effort of this hospital by working safely and attending safety training sessions. Injuries to employees are reviewed on a regular basis to identify safety hazards. Employees, who may have an occurrence or suffer an injury, must report it to their supervisor **immediately,** no matter how insignificant it may seem.

B. OCCURRENCE REPORTING

To ensure that proper attention is given and appropriate action taken when an occurrence involving an employee occurs at work, specific procedures must be followed. If an employee should suffer an illness or injury on the job, **no matter how minor**, the employee must report to the individual in charge of the working area immediately after injury or illness occurs, before reporting to Employee Health (examples: needle punctures, cuts, abrasions, sprains, illness that occurs from previous exposures to patients with communicable diseases).

An "Employee Occurrence Notification" must be completed before the end of shift. The Employee Health Nurse should be notified. If Employee Health is closed, page the House Supervisor. The Employee Health Nurse is responsible for maintaining all Employee Occurrence Reports and records.

C. MEDICAL CARE

- Employees are responsible for reporting work related medical conditions to the Employee Health Nurse **prior** to seeking non-emergency medical assistance, evaluations or treatment by any healthcare provider.
- The Employee Health Nurse will direct the employee to a medical provider.
- The authorized physician will determine the work status of the employee at each visit. The employee must bring this to the Employee Health Nurse after their appointment. If the employee is directed to the Emergency Department a "Return to work Determination" form will be given to the employee.
- All prescriptions, tests, treatments, visits must be approved by the Employee Health Nurse.
- Certain treatments, procedures, tests require utilization review (precertification).
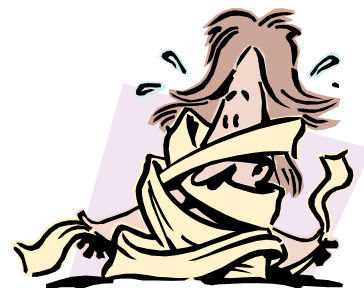
- **ALL FOLLOW UP VISITS FOR WORK RELATED INJURIES OR ILLNESS WILL BE COORDINATED WITH THE EMPLOYEE HEALTH NURSE.**
- The employee will be responsible for communicating with the appropriate department head or supervisor their work status and follow up appointments.

D.   TRANSITIONAL DUTY

In the event there are restrictions placed on the employee following a workplace injury that prevent him/her from performing his usual duties, the employee may be placed in the Transitional Duty Program. This is a temporary program until the employee (lasting no longer than 6 months) can return to full duty. The Employee Health Nurse, who is responsible for work assignments and program qualifications, places employees in transitional duty positions. The employee will be instructed to follow up with the Employee Health Nurse **weekly** until the case is closed.
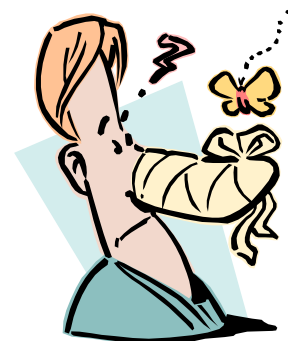
E. POLICY/PROCEDURE COMPLIANCE

Everyone is expected to follow the safety policies and procedures of this facility (see the Safety Manual). Only each individual employee can alter his/her daily conduct that can prevent an injury to himself/herself or a fellow employee; therefore, insistence or adherence to safety procedures is to reinforce safe work habits. Failure on the part of employees to comply with the safety guidelines may result in disciplinary action up to and including discharge.

Preventing Slips, Trips and Falls

Falls in the hospital occur to visitors, volunteers, patients and employees. Help prevent falls by keeping the floor clean and dry. If you see a spill, stop and get help. If it is a small spill, clean it up. If it is too large, have someone call the Environmental Services Department for clean up. DO NOT LEAVE A SPILL UNATTENDED! Place wet floor signs to alert anyone in the area that the floor is wet.

Some of the ways to prevent falls are:

- Observing for leaking equipment- IV tubing, ventilators, respiratory equipment, mop buckets, floor scrubbers, any patient care items that have fluids

- Do not discharge medication out of a syringe or IV tubing onto the floor

- Properly dispose of liquids/secretions from medical equipment

- Wear slip resistant shoes

- Use the umbrella covers located at all entrances keep floors dry

- Cover food and drinks, especially when leaving the cafeteria

- Keep cords off of the floor and out of walkways. If cords must be on the floor temporarily, they should be secured with tape

- Do not place liquids in trash cans, it will leak in the plastic

- When filling cups, coffeepots, etc, observe for spills on the floor

- Remove any visible debris on the floor

- Keep your workspace clean and dry

Rolling Chair Safety

Rolling Chairs come in handy by allowing us to swivel and move easily in our work stations. However, people are sometimes hurt by falling from chairs. This usually results in bumps, bruises, strains and sprains, which can sometimes be treated easily. However, it is important to take adequate precautions to prevent injuries before they occur.

Do's and Don'ts for rolling chair use…

Do:
- ✓ Always keep base of the chair completely on the floor
- ✓ Swivel the chair seat rather than twisting your back reaching to the side.
- ✓ Take care when sitting in a chair with rollers. Make sure it does not roll out from under you.
- ✓ Sit all the way back in your chair and make sure the seat supports your weight evenly. Also make sure the backrest properly supports your spine.
- ✓ Use your chair at the correct height. Your feet should be flat on the floor and knees maintained at 90 degrees.
- ✓ Report any chair damage to your supervisor or maintenance department.

Don't:
- ➢ Don't use your chair for moving from one area to another. Get up and walk!
- ➢ Don't lean so far back in your chair that the wheels or legs lift up off the floor. Leaning can cause the chair to slip out from under you, cause structural damage, or can loosen important connections that can cause the chair to fall apart.
- ➢ Don't roll over uneven surfaces such as cords or carpet thresholds.
- ➢ Never put all your weight at the very front edge of the chair. If you are too far forward, the chair can tip over.
- ➢ Do not climb on any office chair. Use an approved ladder or step stool if needed.

Safeguarding Your Back!!

A major occupational hazard for many healthcare workers is lower back pain or injury. Even if your back feels O.K., you may be doing things to injure it:

- You may have poor posture.
- You may be out of shape or overweight
- You may move incorrectly

Some ways you may reduce the strain on you back include:

- Push instead of pull whenever possible! Not only are you safer, but you can also move more with less effort.
- Avoid carrying loads away from your body with your arms extended. The closer to your body you can carry your load, the less likely you are to injure your back.
- Don't twist while you lift. Back injuries are more likely to occur if you twist while you lift. Twisting your body means that your spine is not correct alignment. You should not twist while you lift. Instead, pivot your hips, keep your shoulders in line and shift your weight. Keep that spine aligned!
- Assess the size of the load. *Can you safely lift it or do you need help?*

Safety is a personal responsibility!!

Injuries to healthcare workers caused by patient transfer/lifting activities directly affects the quality of life for our employees and also results in a dramatic increase in costs for providing patient care. It is crucial that healthcare workers practice safe lifting, transporting and proper lifting techniques at all times. Mechanical lifts are a key component in this effort. Equipment is not located in ED, Family Birthplace and OR.

SARA 2000 is a standing and repositioning aid, for patients up to **400** pounds.

MAXIMOVE is for totally dependent, non-weight bearing patients and is used for all types of transfers and is also used to weigh patients. Maximum weight is **420** pounds.

LIFT WALKER is designed for ambulation training, located in RIWF and Acute PT

MAXISLIDE is designed for repositioning patients in bed and sitting patients up to the bedside to prepare for transfer.

STEDY is to assist the patient that can stand with assistance to move in the room, restroom or hallway. Maximum weight **250**. Located on 4N only.

Ceiling Lifts – ICU and 2N. Maximum weight **600** pounds. 4N has one ceiling lift with a maximum weight of 1000 pounds.

There are many different type of SizeWize equipment available for patients through Supply Chain.

What is Ergonomics?

In simple term, it means improving the fit between your body and an activity.

Why You Should Care

If you don't pay attention to ergonomics, the activities you do today may – over time – lead to a cumulative trauma disorder. Commonly called MSDs (Musculoskeletal disorders), this group of physical problems usually affects soft tissues (muscles, tendons, and nerves) and joints. Although MSDs most frequently affect the back and wrists, your whole body is actually at risk. MSDs can damage finger, elbows, and shoulders, as well as the neck and arms, and even the legs. Left untreated, a MSD may limit your range of motion or reduce your ability to grip objects.

Symptoms of a MSD

MSDs often begin with at feeling of discomfort. You may notice swelling or muscle fatigue that doesn't go away with rest. A muscle may ache, as if it's been overused or slightly strained. Some people feel tingling or numbness. You may wake up at night with the sensation of pins and needles, like when you've slept on your arm too long. At first the discomfort may come and go. But with time, symptoms may become constant. Muscle weakness and nerve problems may develop. Fortunately, by applying ergonomic principles, you can reduce symptoms or avoid these problems altogether.

Avoiding Problems

If you're feeling fit, ergonomics may not seem important. But, over time, strain and overuse can add up to slow down your body. Apply ergonomic principles on and off the job. By doing so, you'll reduce excess wear and tear, making a MSD less likely to occur.

At Work

Using ergonomic principles on the job reduces your risk of developing a work-related MSD. A few simple changes are often all it takes.

At Home

Apply ergonomic principles to everything you do. Live a little smarter. Don't think of ergonomics only at work. After all, a MSD will limit more than your job abilities. Discomfort intrudes on home life, too. What if you couldn't lift your child or carry a pan from the stove to the table? Even simple, everyday activities – like buttoning a shirt may be difficult with a full-blown MSD.

At Work

At Home

Take Ergonomics Personally

Each person's body deals with risks differently. Five people might do the same exact tasks, but it's possible that only one may develop a MSD. What if you're that one? No one can predict. That's why it's important to take responsibility for yourself. Be willing to make changes that reduce *your* risk of injury.

Reduce Risks: Correct Posture Problems

Standing, sitting, and moving incorrectly all increase your risk of MSDs. Why? Because posture problems overwork your body. They strain your muscles and tendons and stress your joints. With a little adjustment, however, you can correct most posture problems. Whatever you do, try to stay near neutral position and work within easy reach. Tasks take less force when you work from a stable base.

Stay Near Neutral

Whether you're standing or sitting, neutral position places the least amount of stress on your body. To find neutral, line up your ears, shoulders, and hips. Keep your head upright and relax while you do this. If you're holding your breath or your shoulders are creeping toward your ears, try again. Your shoulders should be level, with your arms near your sides. You can rest your body by returning to neutral as often as possible.

Keep your wrists straight whenever you can.
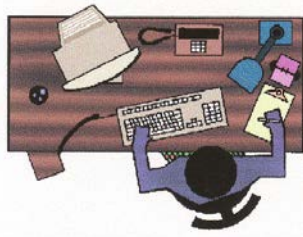
Work Within Reach

Keep your work within reach.

Keep your work within 14 to 18 inches of your body, depending on your size. Reaching too far can be awkward. It also reduces your muscle power, so you need to use more force. Never lock a joint by extending it until it can't go any farther. Also, avoid reaching overhead or behind

Avoid twisting your wrists too far to either side.

Avoid bending your wrists too far up or down.

your back, if you can. If you can't, return to neutral as soon as possible.

A Stable Base

Proper posture reduces strain on soft tissue. When you're in neutral position, your bone structure supports you and provides a stable base to move from. As a result, your movements carry more power, and muscles and tendons don't need to work overtime just to keep you upright. To stay close to neutral, try the tips below.

Face your work. If you need to change direction, move your whole body instead of twisting.

Position yourself so you don't have to stretch or slouch to reach your materials. You should be able to move your forearms straight out from your body to work.

Grasp with your whole hand instead of with just your fingers.

When seated, keep your feet flat on the floor or on a foot support. When standing, put a foot up on a ledge or stool to take pressure off your back.

Clear away clutter between you and your work.

Use task lighting so you don't have to lean over to see your work.

Reduce Risks: Take Good Habits Home

Reducing your risk of job-related injuries is important. But don't stop using ergonomic principles just because your day is over. Activity-related risk factors may be present with anything you do. Have you considered your posture when you're working at a home computer? How about when you watch TV? Anytime you're not near neutral position, you may be straining muscles or joints. And don't forget your personal risks. Your health and habits follow you everywhere.

Be Aware

Whether you're driving in traffic or mowing the lawn, look out for activity-related risk factors. Posture, force, repetition, environment, duration, and recovery time – these risk factors will follow you home. So take good habits home, too. No matter what you're doing, work within reach. Also, don't forget to pick the best tools for the job. This may mean using an electric mixer instead of a wooden spoon, or standing on a stepladder instead of overreaching.

Communication Counts

When it comes to applying ergonomic principles on the job, don't feel foolish about asking for help. If you're at risk for a MSD or if you're already noticing symptoms, don't just "grin and bear it." Talk with your supervisor. Can the risk be controlled? Maybe a co-worker has a suggestion. If you need a medical evaluation, be sure to answer your healthcare professional's questions fully.

Share Concerns With Your Supervisor

If you think your job puts you at risk for a MSD, let your supervisor know. Think through your risk factors. If you

know a way to reduce your risk, suggest your idea. You may already have tried a makeshift control measure that works – wrapping a tool handle with tape to improve the grip, for example. By sharing concerns with your supervisor, you can work together to find a better way of getting the job done.

Exchange Ideas With Co-workers

Do you share a workstation, or are you a part of a group of employees doing the same job? If so, your co-workers may also be aware of MSD risks. Exchanging ideas about work flow, tools, and equipment may be helpful. Perhaps you can find a way of rotating tasks throughout the shift. Using different muscle groups is one of the best ways to reduce repetition and duration.

Reduce Risks: Rearrange your Workstation

You'll probably find that improving your posture requires adjusting your work area, as well as your body position. This is because the way you do a task is affected by where you do it and the tools you use. After all, this is what ergonomics is all about.

Pick the Right Tools

Use the tool that's correct for the job. This reduces force and, possibly, the number of repetitions needed to do the task. Tool handles should extend the length of your hand to avoid pressing into your palm. Keep tools in good repair. The work may go faster, and you'll probably use less force.

A Successful Setup

Whenever you can, make choices that reduce your risk of MSDs. For example: adjust your work height to suit the task being done. For general tasks such as computer keyboard use – the keyboard should be approximately elbow height or slightly lower.

Organize Your Work Area

Once you've found neutral position, set your work area up to help you stay aligned. Direct lighting to shine on your tasks. Raise or lower the work surface, so your movements are as comfortable and powerful as possible. Position tools and materials you use most often within easy reach. And think about your tasks. You can reduce wasted motion by placing incoming and outgoing work in order.

Prepare for the Environment

When work conditions are less than ideal, be prepared. Wear personal protective equipment to reduce the effects of drafts or cold temperatures. Reduce your risk of vibration by using low-vibration tools or by padding tools with vibration –absorbing materials. Dampening mats, cushions, gloves, and shock-absorbing shoes also help.

Identify the Risks

No one can predict who'll get a MSD. In fact, most people never develop one. Even so, you should recognize and reduce any activity-related or personal risk factors.

Activity-Related Risk Factors

The risk factors defined below may be linked with work and home activities. Since each risk factor increased your chances of developing a MSD, think carefully. Are you at risk for any of the following?

- Posture is a problem when you slouch or when you bend, twist, or reach too far. Awkward postures overwork soft tissues and joints. In addition, any body position can be a risk if it's held so long that muscles tense up and blood flow is reduced (static posture).

- Force is pressure or strain on the body. You create force when you grip or when you poll, push, or lift heavy materials. Contact force occurs when you lean or press against a hard surface or sharp edge.

- Repetition is doing the same task or using the same set of muscles over and over again.

- The environment is your surroundings, including cold temperatures, vibration, and lighting.

- Duration is the length of time you are exposed to a risk factor. The longer the duration, the higher your risk.

- Recover time is the amount to time the body needs to rest after performing a repetitive task or being in an awkward posture. Recovery time becomes a risk when the time between activities is not enough to allow the body to recover.

Personal Risk Factors

Some risk factors aren't activity related. Instead they are due to your health and general well-being. Many of these risk factors, such as body weight and fitness level, can be controlled. Others, specifically previous injuries, cannot. These risks are with you for life. And since old injuries sometimes weaken soft tissue3s, they may multiply the effects of any activity-related risks.

Exercises for Minibreaks

Exercises help to relax tight muscles, reduce stress, and lessen the sense of general fatigue that can set in when sitting and concentrating for long periods of time. Choose from the exercises below and do them during the day – right at your desk or computer.

Deep Breathing

Breathe in slowly through the nose. Hold for 2 seconds and then exhale through the mouth. Repeat cycle several times.

Upper Back

With arms folded at shoulder height, push elbows back. Hold a few seconds. Repeat 5-15 times.

Wrist

Hold you hands in front of you Raise and lower your hands to stretch the muscles in the forearm. Repeat several times.

Lower Back

While sitting, slowly bend your upper body between you knees. Hold for a few seconds, then sit up and relax.

Head & Neck

Turn head slowly from one side to the other, holding each turn for the count of three. Repeat 5-10 times.

Shoulders

Roll shoulders forward 5 times using a wide circular motion. Then roll shoulders backward 5 times. Repeat cycle 5-10 times.

Fingers & Hands

Make a tight fist with your hands. Hold for a second. Then spread your fingers apart as far as you can. Hold for 5 seconds.

Legs

Grasp the shin of one leg and pull slowly toward your chest. Hold for 5 seconds. Then do the other leg. Repeat several times.

Ways to Improve Ergonomics of Work Station

Place monitor directly in front of you while at the keyboard

Use a document holder to place source documents as close to the computer screen as possible and at the same height and distance

Tilt or swivel monitor screen to eliminate reflections on the screen, or add an anti-glare filter

Sit with head and neck in an upright position, even while on the telephone

Position top of monitor screen at or below eye level and about an arm's length away

Keep shoulders relaxed and elbows close to the body

Place mouse and other input devices next to the keyboard

Use the backrest of the chair to provide full support, particularly for the lower back

Reduce glare on work surfaces by decreasing overhead lighting and using window shades effectively

Maintain a proper posture, having a 90° or greater angle at the hips and knees while the feet are supported by the floor or a foot rest

Adjust keyboard or chair height to keep forearms, wrists and hands in a straight line while using the keyboard

Use an air cleaner to reduce dust and other airborne irritants

Add a task light to illuminate documents properly

Allow ample clearance to move knees and legs under the keyboard support

Block noise with fabric partitions or use earplugs, music or a small fan to mask noise

Adjust the height of the chair to achieve a proper posture

Select a chair that allows clearance behind knees when seated against the backrest

Hospital Security

Of necessity, the hospital is open at all times. This presents a security challenge. While the Security Department has certain, specific responsibilities, the cooperation of all employees is essential if security risks are to be minimized.

The Security Safety Subcommittee defines a "Security Incident" as any incident that causes harm to employees, visitors, patients or property or has the potential to do so.

Employee Responsibilities:
Be alert to the entry of unauthorized persons in any area. If you see someone who does not appear to be an employee, or even an employee who might be outside his/her regular work area, please offer assistance in directing him/her to his/her destination. Report any suspicious or unusual activity to your supervisor.

Personnel Identification:
>   *All employees should wear employee identification badges while on duty.
>   *Vendors and sales representatives will have identification badges issued through Supply Chain.
>   *Contract construction and service workers will have identification badges issued through Plant Operations.
>   *Visitors will be identified by the absence of any identification badge.
>   * All students must wear their school identification badges at all times while doing clinical rotation.

General Security Responsibilities/Information:
Patients and employees are asked not to bring excessive amounts of money or valuables with them to the hospital. If you observe a patient with what you consider to be an excessive amount of money or valuables, please contact your supervisor.

Employees should secure cash and other valuables in lockers, desk drawers or other secure space while at work.

Consult your unit/department specific security policies, if applicable. This is especially important in security sensitive areas such as the Pavilion, Pharmacy, Emergency Department, and The Family BirthPlace.

Protect any computer/door passwords or combinations. Never share this information with anyone.

Security escort services are available for transportation to parking lots. To access this service, please follow the following procedure:

- Call 698-6916 verbalize your request and location.
- As a last resort, dial "0" and have the PBX operator contact the Outside Officer and convey your request.

The last employee to leave a work area at the end of the work shift should be sure that all doors are locked and the area is secure.

Workplace Violence

Healthcare facilities were once considered immune from the violence of the outside world. This is no longer true.

- In one state, nearly 60% of hospital employees received injuries from patients or visitors.
- As many as $1/3^{rd}$ of all nurses are assaulted each year on the job.

Prevention

There are steps you can personally take to prevent violence and protect yourself.

- Attitude: be friendly and listen
- Respond promptly in a caring manner to help others feel as comfortable as possible.
- Exercise: Your physical ability to react quickly with strength and stamina could help to insure your own protection

Understanding Workplace Violence

Workplace violence is more commonly thought of as homicide, but there are other forms of workplace violence, which include: hitting, shoving, kicking, and sexual assaults

Workplace violence also includes verbal outbursts and can happen in the form of: threats, harassment, abuse, and intimidation

Safety with the Aggressive Patient

Patients in a clinical setting do not always act rational. They, at times, may be insulting, intrusive, offensive, and perhaps assaultive and violent. On or off the job, employees have experienced some degree of aggression as a part of every day living. Anger is a normal response to physical or psychological discomfort. However, when working with patients, it is necessary for employees to have the responsibility for its prediction, prevention and management.

Employees who know that they are going to be working with patients who have a history and/or potential of aggressive behavior need to have a good self-awareness regarding their own responses to anger or aggressive impulses. Discussing with fellow employees as well as role-playing is an effective method of handling anger or aggressive impulse, which will help employees preserve and enhance their own emotional health.

All of the guidelines listed below should be followed when working with the aggressive patient and always ask your supervisor if you have questions or are unsure about a patient's behavior.

- Review the patient's record and pay close attention for history of acting out, aggressive and/or violent behavior, any time an employee is assigned to a new patient.
- Pay particular attention while reviewing the patient's records to when the patient's episodes occur, if there is a history of aggressive behavior.

There are several strategies in working with the potentially violent patient. Clinical judgment and the situation must dictate the appropriateness of their use. Some violent behavior occurs impulsively and without warning; however, most episodes involve an escalation of the behavior and are more amenable to verbal intervention.

Form a verbal alliance. This is the first step when working with the potentially violent patient. Always convey control in the situation by using <u>clear</u> and <u>calm</u> statements and place yourself in a confident physical stance rather than using remarks or cues that can be interpreted by the patient as a challenge from the employee. Employees who handle the situation with an aggressive, threatening manner or have a tendency to over identify with what the patient is experiencing can often make the employee a target of violence.

Establish a relationship. The employee must develop a relationship that minimizes the patient's projection on the helper and yet protect the patient's already damaged self-esteem as much as possible. This will result in decreasing the potential for violent behavior.

Watch for cues that the patient is exhibiting, such as anger, tense facial expressions, forming of a fist, writhing of hands, verbal expression such as "leave me alone", "back off", etc.

Patients may be righteously angry about the healthcare setting; "being locked-up"; anger at other patients who are within the setting, angered by the healthcare giver, angered by the actions of their families who "put them here".

Inform the patient of what task you will be completing: take TPRs, feed them, administer injection or move them.

Respond calmly to the patient, not in a condescending voice i.e., patient states, "That day nurse locked me up on here and I'm mad". Employee response "I can see how that would make you upset". The employee draws attention back to the patient/staff interaction, not targeted specifically on the "day nurse".

Avoid sounding clinical. Use verbiage that the patient can understand. Be prepared to listen and allow ventilation as long as it is productive, which can prevent further loss of control.

Employees might not be able to persuade the patient's reasoning, because at times defensiveness impairs listening. Always keep in mind whether or not the patient's fear or anger is rational.

Later, employees may be able to reflect with the patient and guide how to adequately deal with his/her emotions and make better choices when presented with the situation.

Unfortunately, there are occasions where verbal interaction/communication with the patient is not sufficient, particularly when violent behavior occurs impulsively. Alternate interventions may be used.

You are a member of the healthcare team. Never put yourself in a position where a patient might endanger you. Always ask for assistance from a team member.

Reminder, the code for Violence/Workplace Violence is **"Code Silver"** please refer to page 86 for the full policy review.

Department: Human Resources	Reference Number: **IV – 72**
Policy Description: **Substance Use in the Workplace**	Page 140 of 159
Approved By: OPS – (reviewed **05/11/11with no revisions)**	Replaces Policy Dated: 4/1/07 (HR.210), 11/1/08, 2/1/11
Effective Date: **04/01/11**	Last Revised: (corp: 4/01/11)
Retired:	Last Rvwd w/no chgs: 3/16/11, **5/11/11**

SCOPE: All Company-affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, home health agencies, physician practices, service centers, outpatient imaging centers, and all Corporate Departments, Groups, Divisions and Markets. This policy covers all employees as well as those applying for employee positions.

PURPOSE: To prohibit inappropriate drug or alcohol use by our employees in the workplace in order to prevent a threat to the quality of care we provide to patients, the safety of our workplace and a healthy work environment.

To articulate our intent that all conduct be consistent with all relevant federal, state and local laws and regulations relating to drug or alcohol use by employees (this includes employees and Facilities outside the U.S. and the laws of the country where the Facility is located). To the extent that this policy conflicts with such laws and regulations, such laws and regulations will govern. A state-by-state list of drug-free workplace regulations is available online at http://www.dol.gov/asp/programs/drugs/said/StateLaws.asp.

POLICY:

1. **Assistance**
   a. The Company recognizes that alcohol abuse, substance abuse, and addiction arise out of treatable illnesses. The Company also realizes that early intervention and support improve the success of rehabilitation. To support employees, the Company:
      i. Encourages employees to seek help if they are concerned that they or their family members may have a drug and/or alcohol problem.
      ii. Encourages employees to utilize the services of qualified professionals in the community to assess the seriousness of suspected drug or alcohol problems and identify appropriate sources of help.
      iii. Offers all employees and their family assistance with drug or alcohol problems through the Employee Assistance Program (EAP).

iv. Allows eligible staff the use of accrued paid leave while seeking treatment for drug or alcohol problems.

b. Treatment for alcoholism and/or drug use disorders may be covered by a personal benefit plan. However, the ultimate financial responsibility for treatment belongs to the individual.

2.   **Shared Responsibility**

a. A safe and productive workplace free of inappropriate alcohol or drug use is achieved through cooperation and shared responsibility.

b. It is the responsibility of each employee to:
   i.   Adhere to this policy.
   ii.   Notify his or her supervisor at the Facility of any arrest or conviction involving drugs or alcohol prior to his or her next scheduled shift or clinical duty.
   iii.   Cooperate fully with any investigation related to alleged violations of this policy.
   iv.   Investigate, report, and/or intervene in the event of reasonable suspicion of violations of this policy.
   v.   Safeguard Controlled Substances from unauthorized access.

c. It is the responsibility of each Facility's management to:
   i. Inform employees of this policy.
   ii. Make the policy easily accessible to employees.
   iii. Contract with an accredited reference lab for drug testing, transmit to the lab a copy of this policy, and ensure that the lab has a physician who will serve as a Medical Review Officer (MRO) for testing and interpretation.
   iv. Periodically conduct substance abuse training for supervisors.
   v. Promote employee awareness of the Company's assistance programs, including the Employee Assistance and Rehabilitation Assistance Programs.
   vi. Investigate reports of reasonable suspicion of violations of this policy.
   vii. Take action with respect to violations of this policy. Such action could include counseling with respect to professional help, referral to the Employee Assistance Program, disciplinary action, or termination.
   viii.   If required by accreditation, certification, licensure, or legal requirements, or if

management of the Facility believes it to be appropriate, timely notify the appropriate authorities of any such action.

ix. Maintain all documents pertaining to reports and investigations pursuant to the Records Management Policy, EC.014.

3. **Prohibited Behavior**

a. The following activities are strictly prohibited and may lead to discipline, up to and including immediate discharge:

i. The sale, manufacture, distribution, purchase, use, or possession of alcohol, alcoholic beverages, illegal substances, non-prescribed controlled substances, or drug paraphernalia by an employee on Facility premises or during his or her working hours.

ii. Reporting to work, or being at work, while under the influence of or while impaired by alcohol, alcoholic beverages, illegal substances, prescribed or non-prescribed controlled substances. For the purpose of the Policy, an employee is presumed to be under the influence of alcohol if a blood test or other scientifically acceptable testing procedure shows a blood alcohol level of .04 or more.

iii. Reporting to work, or being at work, with the smell of alcohol on one's breath or person, or a measurable quantity of non-prescribed Controlled Substances in one's blood or urine.

iv. A conviction for sale or possession with intent to distribute any drugs, including prescription drugs.

v. Theft or diversion of facility medications.

vi. Refusal for any reason to submit or consent to a drug/alcohol screen requested by any management personnel at the Facility.

vii. Participation in any act that would create or allow false documentation of security and/or safety practices.

viii. Tampering with or otherwise altering drug testing samples or security equipment or systems.

b. Notwithstanding the foregoing, during facility-sponsored activities, the facility

CEO, Administrator, Practice Manager or individual with senior level responsibility for the facility, at his/her discretion, may approve the responsible and limited serving of alcoholic beverages.

c. Prescription medications are not prohibited under this policy when taken as prescribed under the direction and monitoring of a physician.

4. **Duty to Report, Detection and Reasonable Suspicion**

a. An employee must notify his or her supervisor whenever he or she is taking a prescribed or over-the-counter drug that the employee has been advised will, or based upon the drug profile is likely to, impair job performance (*e.g.*, drowsiness or diminished ability to focus).

b. An employee must notify his or her supervisor if the employee has reasonable concerns that another employee has violated this policy.

5. **Searches**

If a supervisor has a reasonable suspicion that an employee has violated this policy, the supervisor may require the employee to submit to a search or inspection. By entering Facility property, each employee consents to such searches and inspections. Searches can be conducted of pockets, clothing, lockers, wallets, purses, briefcases, lunchboxes, backpacks, duffel bags, desks, work stations, equipment, and other areas. See also the Company's general policy regarding searches in the Theft and Violence in the Workplace Policy, SS.001.

6. **Drug and Alcohol Testing**

a. To ensure the accuracy and fairness of our testing program, all collection and testing will be conducted pursuant to guidelines established by the Medical Review Officers and, if applicable, in accordance with Substance Abuse and

Mental Health Services Administration (SAMHSA) guidelines; a confirmatory test; the opportunity for a split sample; review by an MRO, including the opportunity for employees who test positive to provide a legitimate medical explanation, such as a physician's prescription, for the positive result; and a documented chain of custody.

b. All drug-testing information will be maintained in separate confidential records.

c. Employees will be required to participate, at a minimum, in testing as follows:
   1) post offer, pre-employment;
   2) prior to an acquisition which includes the employment of the seller's employees, Corporate Human Resources will compare the seller's drug testing policy to this policy in the required due diligence process and will make a recommendation to the Division President expected to operate the newly acquired business based on that comparison.
   3) upon reasonable suspicion;
   4) after a reportable accident; and
   5) after an on-the-job injury to any person (*e.g.*, another employee, a patient, the person to be tested) when it is possible that the acts or omissions of the employee to be tested may have caused or been partially responsible for the injury.

d. Substances tested for at hire must at a minimum include amphetamines, barbiturates, benzodiazepines, opiates, marijuana, codeine, and cocaine. Reasonable suspicion and reportable accident testing should include amphetamines, barbiturates, benzodiazepines, carisoprodol, opiates, fentanyl analogues, methadone, meperidine, marijuana, and cocaine.

e. Testing for the presence of alcohol will be conducted by analysis of breath, saliva, blood or other accepted testing methodology.

f. Testing for the presence of the metabolites of drugs will be conducted by the analysis of urine, blood, saliva, or other accepted testing methodology.

g. The MRO will review all non-negative reports. Any non-negative drug test result due to a physician-approved medication will be reported as a negative result. If it appears that the person tested is impaired by the use of medications for which the employee has a valid prescription, the report should note that fact. Medications that could affect an applicant's ability to perform his or her job may result in restrictions or recommendation for accommodation with respect to those tasks.

7. <u>Violations of Policy</u>

Employees will be subject to discipline, including possible termination, if they violate this policy in any way.

8. **<u>Pre-Employment Tests</u>**

With respect to a person who has been offered employment, if the person refuses to take the pre-employment drug tests described above, or tests positive for any non-prescribed Controlled Substances or Illegal Substances, the offer of employment will be withdrawn.

<u>DEFINITIONS</u>:

Controlled Substances: any drug or chemical substance whose possession and use are regulated under the Controlled Substances Act.

Illegal Substances: any drug the possession or sale of which violates federal law (in the U.S.) or the country, state or local law of the jurisdiction in which the Facility is located.

Impairment: Practitioner impairment occurs when a substance-related disorder interferes with his or her ability to engage in professional activities competently and safely.

Medical Review Officer (MRO): A licensed physician not employed by HCA or an HCA affiliate who oversees the medical aspects of this policy. The MRO could be affiliated with the reference lab contracted with by the Facility. The MRO should have appropriate medical

training to interpret and evaluate an individual's positive test results, medical history and any other relevant medical information.

HCA Affiliate: any entity (partnership, corporation, joint venture, LLC, etc.) that HCA ultimately owns or controls 50% or more of, including its 50% owned joint ventures.

Facility: a facility owned by an HCA Affiliate, including, but not limited to, hospitals, ASCs, urgent care and imaging centers, billing offices, revenue service centers, and corporate, division, and market offices.

Reportable Accident: Any employee involved in an on-the-job accident which involves injury requiring medical treatment or evaluation to the employee or another person, property damage, or lost time from the job will be required to be tested for drugs and alcohol. An exception may be made provided it is immediately apparent to management that the employee is not at fault.

PROCEDURES:

1. ### General

   a. Upon notification that any person has a reasonable suspicion that an employee of a Facility is violating, or has violated, this policy, the leadership of the Facility shall conduct an investigation. If, after an initial investigation, there appears to be some credibility to the suspicion, the Facility shall take whatever action necessary to protect patients and employees, including, if the circumstances indicate that it is appropriate, immediately removing the employee from his or her work area and escorting him/her to a designated testing location, and conducting a search of the work area. The employee will be asked to sign a consent form prior to testing.

   b. Any employee who is tested based upon a reasonable suspicion of a violation of this policy shall be immediately suspended pending results.

   c. Any employee whose blood alcohol content exceeds the maximum set forth in this policy, or tests positive for non-prescribed Controlled Substances or illegal substances, will be immediately suspended. The Facility shall then seek legal review by the employment section of the Legal Department.

d. During a suspension for violation of this policy, the employee shall not be allowed access to the Facility with the exception for medical treatment.

e. The Facility will provide employees who test positive with contact information for substance abuse resources.

2. <u>Voluntary Self-Reporting</u>

An employee who voluntarily self-reports substance abuse may, in the Facility's sole discretion, be offered an opportunity to participate in a rehabilitation program. In such cases, the Facility may require, as a condition of continued employment, that the employee abide by the terms set forth by the Facility.

3. <u>Organizational Reporting</u>

In the event of a violation of this policy, the Facility will, if required by law, or if not required then if the Facility deems it appropriate, notify: (a) governmental agencies with jurisdiction over drug and alcohol issues (*e.g.*, police, FDA, DEA); (b) if applicable, any professional licensing boards; and (c) appropriate Company executives (*e.g.*, Division, HR, Legal, PR, Risk Management, HCI).

4. <u>Confidentiality</u>

All information received by the Facility through compliance with this policy is confidential. Access to this information is limited to those who have a legitimate need to know within the Company or those outside the Company in law enforcement.

5. <u>Communication and Training</u>

Communicating this policy is critical to the Company's success. To ensure all employees are aware of their role in supporting this policy, each Facility shall prepare a plan for ensuring:

a. The policy will be reviewed in orientation sessions for all employees.

b. The policy will be reviewed annually by all employees.
c. Leadership/designee will discuss the policy and organizational procedure during orientation of staff managers.

6. **<u>Financial Reporting</u>**
   a. Charges for employee drug screens, physician physicals, and fit for duty physicals should be reported under Account Title: Post Employment Drug Screens/Physicals #294.

   b. Charges for potential employee drug screens, physician physicals, and fit for duty physicals should be reported under Account Title: Pre-employment Backgrounds/Drug Screens/Physicals #866.

7. **<u>Policy Monitoring</u>**
   Monitoring of policy compliance will occur through Compliance Process Reviews by the Corporate Ethics and Compliance Department and Quality Review System Surveys by the Clinical Services Group.

REFERENCES:

Records Management Policy, EC.014

Theft and Violence in the Workplace Policy, SS.001

Pre-Employment Health and Drug Screen Process Flow Charts

(replacing CSG.MM.002 – last approved corp version (eff: 4/1/11) at WFH on 05/11/11)

O.M.E.N.
POST TEST

WEST FLORIDA HOSPITAL
EDUCATION AND PROFESSIONAL DEVELOPMENT SERVICES
O.M.E.N.: ORIENTATION MANDATORY EDUCATION NOTEBOOK POSTTEST

POST TEST

(DO NOT WRITE ON THIS TEST! USE THE ANSWER SHEET PROVIDED)

MISSION, VALUES & GUIDING PRINCIPLES

1. All of the following are patient rights, except:
   a. Right to get treatment regardless of age, race, sex, handicap, marital status, national origin, or source of payment for care.
   b. Right to refuse medical treatment to the extent permitted by law and to be informed of the consequences of refusing treatment
   c. Right to privacy during examination, treatment, and when discussing his case. This means out of the sight and hearing of people not involved in his care.
   d. Right to have all care provided without cost to the patient.

2. It is required for an employee to park in designated "employee parking" areas to allow for patient access to hospital services.

   a.   True   b.   False

3. All personnel are needed and expected to report to work when scheduled. In the event of an unexpected illness, family emergency or need to change your work schedule, it is **NOT** your responsibility to notify anyone.

   a.   True   b.   False

4. All of the following are true **except**:
   a. Flip flops or sandals are not permitted in clinical areas.
   b. Body piercing should not be visible, except for earrings, which cannot exceed 2 earrings per ear.
   c. Due to negative reactions, the use of strong perfumes or after-shaves are prohibited.
   d. Bare midriff shirts and short skirts are permitted as proper dress attire.

PATIENT CONFIDENTIALITY

5. Protected health information includes the patient's:
   a. Social Security Number
   b. Address
   c. Age
   d. Name
   e. All of the Above

6. Confidential Information includes all of the following except:
   a. Computer network configuration
   b. User ID
   c. Passwords
   d. Marketing strategies

7. Who is responsible for protecting patients' individually identifiable health information?
   a. Chief Nursing Officer
   b. Ethics and Compliance Officer
   c. Physician
   d. All staff

8. Confidential Information must not be shared with another unless the person has:
   a. An OK from a doctor
   b. The need to know
   c. Permission from Human Resources
   d. All of the above

9. Patients have a right to access their health information.

   a. True   b. False

10. What is the standard for accessing patient information?
    a. A need to know for the performance of your job
    b. If a physician asks you the diagnosis of the patient
    c. Just because you are curious
    d. You are a relative of the patient

11. Any confidential information stored on laptops, flash drives or computers must be
    encrypted to protect patient privacy.
    a. True   b. False

12. You can be held personally responsible for commentary that is considered defamatory,
    obscene, proprietary or libelous by any offended party, not just HCA?
         a.   True   b. False

13. If an employee has medical testing at an HCA facility, the appropriate way for him or her to
    access the test results is:
    a. Complete the release of information form in HIM and receive a copy of the results
    b. Check the Meditech computer system for his or her own results
    c. Get a fellow employee to access the results while looking over his or her shoulder
    d. Call a friend in the department where the test was done to get the results for the
       employee

14. Patients are required to sign a form acknowledging receipt of the facility's Notice of Privacy Practices.
    a. True   b. False

15. Under the privacy rule each hospital must designate _____ who is responsible for the development and implementation of privacy policies and procedures for the facility.
    a. A Facility Privacy Official
    b. A Police Officer
    c. Supervisor
    d. A mediator

16. Copies of patient information may be disposed of in any garbage can in the facility.
    a. True   b. False

17. A visitor who asks for a patient <u>by name</u> may receive the following information <u>except</u>:
    a. Patient room number
    b. Patient condition in general terms (e.g. stable, critical, etc.)
    c. Patient unit
    d. Patient diagnosis

18. It is appropriate to share your computer password when:
    a. co-worker forgets his/her password
    b. vendor asks for access to the network to perform maintenance
    c. when training a new employee on his or her computer
    d. when training a student
    e. none of the above

PATIENT SAFETY

19. When transporting a patient by stretcher, you should:
    a. Keep the patient within your vision, raise the side rails, and transport the patient feet first.
    b. Transport the patient headfirst so you can see the patient better.
    c. Leave the patient at the elevators while you go back to the unit to get the chart.
    d. Leave the side rails down at the patient's request.

20. Any patient being transported anywhere must have the same level of oxygen support that he received in his room.
    a. True   b. False

21. A patient that you are transporting to X-ray begins complaining of severe chest pain. What should you do?
    a. Transport the patient to X-ray.
    b. Call the patient's doctor.
    c. Take the patient to the nearest nurses' station.
    d. Call the floor and ask them to come check the patient.

22. You discover that your three-pronged cord is missing a prong. What should you do?
    a. Complete Clinical equipment maintenance request form identifying problem ex: "cord missing prong" attach to equipment send for repair.
    b. See if it will work without the third prong.
    c. Plug it into another cord that has three prongs.
    d. Insulate the cord with UL-approved electrical tape.

23. A piece of medical equipment fails and a patient has been harmed as a result. What should you do?
    1. Return the equipment to CSR and say nothing
    2. Change the settings and try the equipment again.
    3. Complete an Occurrence Report and notify the risk manager
    4. Notify your supervisor
    5. Contact Biomedical Services. Do not change the settings or dispose of any of the parts, components or wrappings. They should be retained with the device.
    6. Notify the patient's physician and follow orders regarding obtaining replacement equipment and resuming or continuing therapy.
       a. #1 only   c. #2 & 6 only
       b. #2, 3, 4, & 6 only   d. #3, 4, 5, & 6 only

24. The nurse has determined that Mr. Jones is at high risk for falls. Which of the following would be appropriate actions to consider?
    a. Assess physical symptoms to determine reasons for risk of falls.
    b. Evaluate patient for need of an assistive device, like a walker.
    c. Provide clear path to bathroom.
    d. Provide for appropriate lighting and footwear.
    e. All of the above.

25. You can be sure that you have identified the right patient for the right treatment, medication or procedure by:
    a. Checking the patient's armband and asking the patient to state his or her name.
    b. Calling out the patient's name, since the person answering will be the right patient.
    c. Checking the name on the chart for that room, since that will be the name of the person in that bed.
    d. None of the above

26. The use of Restraints should be limited to emergencies where there is a risk of the patient harming himself/herself or others.
    a. True   b. False

27. The "emergency" electrical outlets should be used for only life sustaining equipment (i.e. ventilators). The "emergency" electrical outlets are color coded to differentiate them from the "regular" electrical outlets. What color are the "emergency" outlets?
    a. Black   c. Orange   e. Yellow
    b. Red   d. Blue

28. Miss Johnson is receiving large doses of Demerol to manage her post-operative pain. The Demerol helps the pain, but it does make her very sleepy and disoriented. She wants to go outside to smoke. Should the cigarettes and lighter be left at her bedside within her reach ?
    a. Yes   b. No

29. If you are called back to work because of a disaster, you should use your employee KRONUS badge to identify yourself to security or police personnel.
    a. True   b. False

30. While working in your area, you hear over the loudspeaker a **"Code Green**" Level 3." This would mean that there has been a disaster with:
    a. 0-15 casualties
    b. 16-30 casualties
    c. More than 30 casualties
    d. None of the above

31. If a utility power failure occurs, the first "backup" generator will automatically begin working to provide emergency power within 10 seconds.
    a. True   b. False

32. When emergencies (such as hurricanes) cause the phone system to go down, the hospital cannot communicate with areas outside of the facility.
    a. True   b. False

33. The hospital has an agreement with several major companies who will provide water, supplies and drugs during an emergency.
    a. True   b. False

34. When using a fire extinguisher: What does "PASS" mean?
    a. Point, Alarm, Shake, Shout   b. Pull, Aim, Squeeze, Sweep
    c. Push, Act, Select, Save   d. Pressure, Amount, Solution, Size

35. While eating lunch in the cafeteria, you hear a **"Code Red"** called for your unit/department. Your correct action would be to:
    a. Remain in the cafeteria until the Code Red is cleared.
    b. Take the nearest elevator to your unit/department as quickly as possible.
    c. Call your unit/department to see if your help is needed.
    d. Proceed to your unit/department via the stairs and await emergency assignment as needed.

36. What is the code for a fire?
    a. Code Red   c. Code Fire
    b. Code Blue   d. Code 505

37. You discover a fire in your department. You have rescued individuals from the immediate fire by evacuating patients through two sets of fire doors. You should now:
    a. Extinguish the fire.
    b. Open all windows and doors to let out the smoke.
    c. Call the Ferry Pass Fire Department immediately.
    d. Pull the nearest fire alarm and call 4111.

38. Respiratory and/or cardiac arrest with BLS in progress is called a:
    a. Code 505
    b. Code Red
    c. Code 3
    d. Code DNR

39. You discover an unresponsive person beside your car in the hospital parking lot. You have a cellular phone in your car. What do you do first?
    a. Call 911
    b. Call the hospital operator by dialing 494-4111 and state "Code G" and the location.
    c. Call home and tell them you'll be late
    d. Call your department to speak with your supervisor

40. What does code "**Brown**" mean?
    a. Someone has fallen and can't get up.
    b. Manpower needed on a unit.
    c. Fire.
    d. A severe weather warning has been issued; tornado may be coming.

INFECTION CONTROL

41. We use Standard Precautions for all patients. What are the three types of Isolation Precautions we use?
    a. Droplet Precautions; Universal Precautions; Respiratory Precautions
    b. Contact Precautions; Droplet Precautions; Airborne Precautions
    c. Contact Precautions; Respiratory Precautions; Droplet Precautions

42. Various control measures used to prevent spreading bloodborne pathogens include:
    a. Sharps disposal containers
    b. Personal protective equipment
    c. Handwashing
    d. Standard precautions for all patients
    e. All of the above

43. Which of the following is (are) true regarding the disposal of dirty linen?
    1. Put all bed linens in the pillowcase.
    2. It is an acceptable practice to throw an occasional piece of loose linen down the linen chute.
    3. Bloody linen is placed in a red bag and other linen is placed in a yellow bag.
    4. Put all linen in a yellow bag even if it is contaminated with blood.
    5. Close linen bags before placing them down the linen chute.
        a. 1 and 2   d.   4 and 5
        b. 2 and 3   e.   5 only
        c. 3 and 5

44. Which of the following statements about handwashing is **not** true?
    a. Handwashing is the single most important technique in preventing the spread of infections to patients and employees.
    b. Handwashing is not necessary if gloves are worn.
    c. Limiting jewelry worn will make handwashing more effective.
    d. While handwashing, you need to rub your hands for at least 10-15 seconds.

45. A syringe with a needle attached can be thrown away in the toilet.

    a. True   b. False

RISK MANAGEMENT

46. A Living Will is the same thing as a "Do Not Resuscitate" order:
    a. True   b. False

47. A statement identifying someone as a health care surrogate is signed by:
    a. The Physician
    b. The Patient
    c. The Patient's family
    d. The Patient's attorney

48. What should be on the occurrence screen in Meditech?
    a. Hearsay
    b. Facts
    c. What you thought happened
    d. Only what the doctor said

49. Any injury should be reported immediately and an occurrence screen should be done as soon as possible and prior to the end of the shift.

    a.   True   B.   False

50. Which of the following findings might indicate abuse?
    a. Evidence that injuries are in different stages of healing.
    b. Questionable cause of injuries.
    c. History of previous episodes.
    d. All of the above.

51. What action should the health care worker take if abuse is suspected?
    a. Do nothing unless the patient said someone harmed her.
    b. Do nothing, because abuse is only suspected. It has not been proven.
    c. Report the findings to a supervisor, who then calls the physician, RN, Administrative Supervisor, Department Head and/or Case Manager.
    d. Give the number of the Abuse hotline to the patient and tell her to call.

52. The term "abuse" includes neglect, malnutrition, severe physical injury inflicted other than by accident, and failure to provide sustenance (food) clothing, shelter, or medical attention.
    a. True   b. False

PROCESS IMPROVEMENT

53. Sentinel events include events that have resulted in unanticipated death or major permanent loss of function, not related to the natural course of the patient's, client's, or resident's illness or underlying condition.
    a. True   b. False

54. To meet our customers' expectations we must do all of the following:
    a. Inform our customer of anticipated treatment.
    b. Meet customer expectation of quality.
    c. Listen to our customers.
    d. All of the above.

EMPLOYEE SAFETY

55. If an employee receives a small, insignificant injury, there is no need to complete an Occurrence Report.
    a. True   b. False

56. Back injury is more likely to occur when twisting during lifting.
    a. True   b. False

57. When moving large objects, it is better to pull than push.
    a. True   b. False

58. To reduce the stress on your back, you should:
    a. Hold loads away from your body
    b. Hold loads close to your body
    c. Carry loads with one arm
    d. Any of the above methods, as long as you are careful

59. You could be causing damage to your back, even if it doesn't hurt.
    a. True   b. False

60. As an employee of West Florida Hospital, you are required to wear your name badge on your collar in visible sight while on duty.
    a. True   b. False

61. You observe a stranger wandering around in your work area. The stranger is not wearing an identification badge of any kind. The correct action is to:
    1. Do nothing. He/she is probably just a lost visitor.
    2. Offer assistance in directing the stranger to their stated destination.
    3. Notify your supervisor or Security of any suspicious or unusual behavior.
    4. Aggressively confront the stranger and demand to know who they are and what they are doing in your area.
        a. 1 only   c. 4 only
        b. 2 & 3 only   d. 3 & 4 only

62. Verbal threats, harassment and intimidation are forms of workplace violence and should be reported.
    a. True   b. False

63. What is an "MSDS"?
    a. Material Safety Data Sheet
    b. Mandatory System of Dilution of Substances
    c. Multiple Substance Disposal system
    d. Morbidity of Substance Disclosure Sheet

64. Employee responsibilities for handling hazardous materials **do not** include:
    a.   Following established rules for handling chemicals.
    b.   Using personal protective equipment as required.
    c.   Memorizing all details found on the MSDS that apply to your area.
    d.   Telling the supervisor about missing labels or damaged containers.

65.	There has been a spill of a hazardous chemical in your work area. Which of the following is the most correct sequence of events?
	a.	1) Call Environmental Services. 2) Obtain the MSDS 3) Evacuate visitors, patients and co-workers from the immediate area.
	b.	1) Call 911 and request the HazMat Team. 2) Complete an occurrence report 3) Notify your supervisor 4) Obtain the MSDS for the spilled chemical
	c.	1) Evacuate patients, visitors, and co-workers from the immediate area of the spill 2) Notify your immediate supervisor 3) Call Plant Ops. 4) Obtain the MSDS for the spilled chemical.

66.	A man is very angry at the hospital and forces his way into the Hospital Administrators office and holds the CEO as a hostage. The secretary calls the hospital operator at 4111 and states what is happening. Which code is best used for this situation?
	a	Code Yellow - Lockdown - no admittance
	b.	Code Silver – Hostage Situation/weapons
	c.	Code Orange - Hazmat/Bioterrorism
	d.	Code Black - Bomb threat

67.	The emergency room has just cared for 3 members of a motorcycle gang with gun shot and knife wounds. The victims tell the nurse that the other gang is going to come here to kill them. The physician calls for a "Lock Down" (no entry). Which silent code is best used for this situation?
	a. Code Orange - Hazmat/Bioterrorism
	b. Code Black - Bomb threat
	c. Code Silver - Hostage Situation/weapons
	d. Code Yellow - Lockdown - no admittance

68.	Fifteen people come into the ED and state they have been sprayed with some sort gas and are having problems breathing. This is a "Code Orange" and is a bio-hazmat situation. The employee calls the operator at 4111 and gives the location. This is a silent code and the operator will notify the appropriate personnel and appropriate in-hospital staff.
	a. True		b. False

69.	The hospital operator receives the silent alarm from the Credit Union which means they are being robbed. Which code is best used for this situation?
	a.	Code Black - Bomb threat
	b.	Code Yellow - Lockdown - no admittance
	c.	Code Orange - Hazmat/Bioterrorism
	d.	Code Silver - Hostage Situation/weapons

70.	Your phone rings; you pick it up to answer the call and a male voice states he has placed a bomb in your facility. You do not leave the phone but have another employee call the hospital operator (4111). The operator would then call which of the following silent code?
	a. Code Silver - Hostage Situation/weapons
	b. Code Black - Bomb threat
	c. Code Orange - Hazmat/Bioterrorism
	d. Code Yellow - Lockdown - no admittance